

**REPRESENTATION OF MENTAL ILLNESS: AN
EXAMINATION OF MOVIES AND PROFESSIONAL
PERSPECTIVES IN NIGERIA**

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ABSTRACT

Representation of mental illness: An examination of movies and professional perspectives in Nigeria

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This thesis explores the social implication of representations of mental health issues in movies produced in Nigeria, by using Critical Discourse Analysis as a mode of textual analysis within the social constructionist tradition, while also employing narrative theories as a framework for the interpretation of data. The perceptions of movie producers and mental health care providers on media representations of mental health issues were compared with results of a content analysis of ten Nigerian movies, by focusing on the analysis of emergent themes and narratives in the data. To explore the extent to which media, particularly fictional narratives, convey mental health issues in Nigeria, a unique coding scheme was developed for content analysis of data from movies and interviews, which brought to light a variety of discourses on the perceptions of movie producers and mental health professionals on issues bordering on stigma, causes and forms of treatment associated with mental illness. The themes produced in the movies chosen (of media representations of mental illness) showed that alternative modes of causal explanation for the problem predominated over psychiatric modes, confirming existing studies. Central to this study is the identification and analysis of the causes, treatment and stigma attached to mental illness in movies, with a particular focus on the social implication of these representations. This study concludes that movies represent modern psychiatry only poorly; that the need to produce sellable media messages impacts on the construction and on-screen

portrayal of mental health issues; and that perceptions of violence portrayed in 'Western' media appear different from representations of violence in Nigerian media.

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CHAPTER ONE

INTRODUCTION

1.0 FOCUS OF THE STUDY

Central to this study is the identification and analysis of the themes that emerge from the cinematic representation of mental illness, with a particular focus on the social implication of these representations. Movies are perceived to constitute an important source of information about mental illness and social change (Borinstein 1992 in Vogel *et al.* 2008). This is separate from, but related to those views that argue that the media serve as vehicles for transmitting mistaken information about mental illness. In line with this thought, some studies argue that the media constitute a source of misinformation in relating the causes, symptoms, manifestations of stigma and treatment of mental illness (Wahl 1992; Knifton and Quinn 2008; Atilola and Olayiwola 2011). In order to enhance existing knowledge on the ways in which media serve as a conduit for providing information or misinformation on important social issues, this study will contribute to knowledge by critically analysing mental health themes in movies produced in Nigeria, while comparing these themes with the perceptions held by movie producers and professional psychiatrists who work in Nigeria.

There are conflicting views on the roles movies play in the formation of knowledge on social issues such as mental illness. In an explanation on how knowledge is formed through exposure to media content, Gerbner *et al.* (1986) argue in favour of a *cultivation process*, a media theory that explains how, variously, heavy or light exposure to certain images in television can affect the way social issues are perceived and understood by members of social groups. In other words, cultivation theorists hypothesize that exposure to television will have influence on a person's intention, general expectations, and specific attitudes and behaviour towards an issue (Vogel *et al.* 2008). On the other hand, Berger and Luckmann (1966) argue that knowledge of human reality is constructed or deconstructed using symbolic forms, such as language and images to form subjective meanings of events in the subjective world. This means that interpretations of social events are dependent on the normative meanings that are socially and culturally ascribed to them. By way of illustration, constructed symbols of mental illness in movies rely on similar constructions in social interactions for it to be meaningful, thus arguing for the concept that movie representations are social constructions of perceived reality. However in this study, while using Critical Discourse Analysis (CDA), it will be

argued that the symbolic representation of mental illness in movies has a serious implication for identifying, interpreting and explaining the socially situated knowledge of mental illness.

The adoption of Critical Discourse Analysis as a realist approach in this study is aimed at developing analytical frameworks for explaining discourses on movie and mental health issues (Fairclough 2013). CDA in this study is a systematic trans-disciplinary analysis of the relations between movie texts, mental illness, and professional views in order to identify, explain and provide suggestions for mitigating some social wrongs that are associated with social and movie representations of mental illness. An assessment of views on mental illness and movie representations, differentiating between what might exist, and what *should* exist on the basis of a coherent set of values will constitute a central aspect of the use of CDA in this study (*Ibid*). In other words, CDA in this thesis will examine discourse as it appears in the dominant themes of mental illness; in ‘absent’ themes (references that should exist but do not) and the implication of this absence; the meaning of the narrative structure of movies to the distribution of power in semantic representations of mental illness; and the structures of texts

in relation to wider structures of global or local contexts (Meyer 2001; Wodak and Meyer 2001; Van Dijk 2001; Van Dijk 2005). In addition, this study will explore mental health issues from perspectives that range from the varied representations of stigma to the diverse views of social groups on what constitutes mental illness across cultures.

Academics from various cultural backgrounds (Wahl 1992; Aina 2004; Atilola and Olayiwola 2011; Birch 2012; Cross 2010; Islam and Campbell 2014) have criticised media representations of mental illness that differ from science based guidelines. The adoption of psychiatry in the diagnosis and treatment of mental illness and the need for movies to represent madness in strict adherence to guidelines set by psychiatry have enhanced the practice of crediting or discrediting familiar images of mental illness in movies. So, in order to adopt verifiable categories, genres and styles that movie and interview texts draw upon, it is necessary to start with the basic symptoms of mental illness using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994). This can be compared with: the identification of certain images as indicative of mental illness; the selection of movies with mentally ill characters; and further analysis of images of mental illness in the various texts.

Social beliefs in Nigeria, an African socio-cultural setting from which the movies were selected, thrive on magic and supernaturalism in their standard explanation of social occurrences. In order to embrace this significant perspective in the social and movie representation of mental illness, an *alternative, non-scientific perspective* of interpreting causes and treatments of mental illness, has been included in the analysis of movie and interview texts. This alternative view has been adopted to explain how themes of mental illness that would usually be seen in a medical context, actually evoke interpretations of magic, spiritualism and supernaturalism. Spiritualism and supernaturalism have a semantic relation that alludes to belief in the supernatural, a fundamental conviction which is supported by different religions of the world. Magic differs slightly from spiritualism and supernaturalism because it involves rituals or actions that are based on supernatural or occult knowledge that fall beyond the realm of religion (Wiktionary 2002). For example, Aina (2004), Atilola and Olayiwola (2011) argue in their analysis of movie representations of mental illness that belief in alternative causes and treatments of mental illness are prominent in movies produced in Nigeria. The crux of their argument was to discredit alternative methods of representing mental illness in movies whilst advocating for

psychiatry as a better method for diagnosing and treating mental illness. This study will advance existing studies by examining the causes and treatments of mental illness from the alternative perspective mentioned above, while focusing on the ways in which magical, supernatural or spiritual representations of mental illness are representative of popular views on mental illness, and the implication of this popularity for the future of both general 'social' attitudes, and specific movie representations of mental illness.

Before the possible historical and empirical complexities of media representation of mental health issues are addressed, the objectives of this study are explained in the paragraph that follows. Ten movies produced in Nigeria, containing themes of mental illness, were selected for analysis to explore the extent that media, particularly fictional narratives, convey mental health issues in the country. The selection of movies in this study is, therefore, informed by prior knowledge of those movie plots that feature themes associated with mental health. Content analysis of mental health themes in Nigerian cinema are compared with perceptions held by movie producers and psychiatrists on media representations of mental illness, in order to enhance the development of

frameworks for explaining the emergence of discourses in the Nigerian context.

A number of interdisciplinary studies have examined media representation of mental health themes (Philo *et al.* 1996; Rose 1998; Knifton and Quinn 2008; Cross 2010; Birch 2012; Sapouna 2012). Studies on mental health issues are engaged in by academics from the field of psychiatry (Gureje *et al.* 2007; Atilola and Olayiwola 2011), media, cultural studies and social science related disciplines (Philo *et al.* 1996; Rose 1998). Interdisciplinary studies here bring together theories from psychiatry, anti-psychiatry, media and cultural studies for the purpose of discoursing the categories, concepts and actual texts associated with portrayals of mental illness. Given the requirement for engaging in interdisciplinary studies, this study will examine the dialectic established between mental illness as an aspect of psychiatry (a science based discipline) with concepts, categories and theories of mental illness that reside within humanities and social science disciplines via the analysis of semiotic modes in movies.

This study is intended to advance knowledge on existing studies that have investigated media representations of mental health issues by focusing on the social implication of representations of mental illness in narratives produced in Nigeria. Some studies present quite a number of assumptions on media representations of mental illness in different social contexts (Wahl 1992; Philo *et al.* 1996; Rose 1998; Wahl 2003; Aina 2004; Thornicroft *et al.* 2007; Knifton and Quinn 2008; Vogel *et al.* 2008; Owen 2012; Maier *et al.* 2013). A popular critique of media representations of mental illness is that these representations are unrealistic, inaccurate and likely to misinform the audience (Wahl 1992; Henderson 1996; Knifton and Quinn 2008). Furthermore, other studies that investigated frames of mental health in the media have focused on the portrayal of the causes of mental illness; on the attitudes or beliefs relating to mental health issues; on notions of stigma (Abdullahi and Brown 2011; Clement *et al.* 2013; Corrigan and Shapiro 2010; Philo *et al.* 1996; Wahl 2003; Knifton and Quinn 2008); and on the attitude of people to images of mental health (Demyan 2009).

In addition, studies that have explored the significance of perceptions held by professional mental health care providers on media representations of mental illness may be scarce.

Clement *et al.* (2013) reports in a library based study that no empirical study on mental health, at the time of writing their report, examined the perception of mental health professionals in relation to media representations of mental health issues. However, in the examination of the role mental health professionals play in the construction and sustenance of mental health stigma, Lammie *et al.* (2010) have argued that mental health professionals themselves actually constitute a source of mental health-related stigma, however minor this may be compared to other sources. Another way this study will contribute to knowledge involves the incorporation of interview analysis of psychiatrists and psychologists to the research method in an attempt to build on the works of Clement *et al.* (2013) and Lammie *et al.* (2010).

In sum, attempts will be made at identifying and analysing distinctive elements of mental illness contained in selected movies, with the aim of enhancing the exploration of a well-directed investigation of movie representations of mental health issues in Nigeria, while adding a unique dimension to the corpus of researches on media and mental health issues by accessing the perceptions of movie producers and

psychiatrists on media representations, and of causes and treatments of mental illness in Nigeria.

However, this study will not measure the impact of mental health images on audiences. In other words, this is not an audience or ethnographic study. The exclusion of this kind of approach (where a selected audience will be exposed to media images with mental health themes) is premised on the need to focus more on the content of the movies, while at the same time avoiding any notion that this is an analysis of effect. Another important point is that the professional producers and mental health care providers, who were interviewed in this study, were not exposed to images of mental illness before or after the interview. Information sourced from these respondents relied solely on what the respondents know or perceive of media representations of mental illness. Since this study is aimed at unravelling power relations in inter-discursive texts, it cannot suggest reasons to respondents why certain themes of mental illness are dominant over others. It is hoped that further study will explore the option of analysing movies produced in the Hausa and Igbo languages in order to assess a broader perspective of media representation of mental health issues in Nigeria as a whole,

since this thesis deals with two particular language groups only.

1.1 MADNESS OR MENTAL ILLNESS: CONCEPTS AND MEANINGS

According to academics in the field of psychiatry, mental illness is a concept that encapsulates a broad spectrum of meaning and interpretation (Szasz 1987; Gilman 1988). A more specific interpretation of mental illness suggests the presence of disease in an 'other' (Foucault 1965; Szasz 1987). The use of 'illness' as a term for the description of the suffering of an 'insane person' or as an artefact of the society was the basis of Szasz's argument around insanity. Szasz focussed on denouncing 'mental illness' and described it as a 'man-made myth' (Porter 2002). For Szasz, 'diseases' can be created regardless of their biological, emotional and psychopathological source. In simple terms, Szasz's argument is that mental illness is a man-made disease that psychiatry fabricated in the interest to 'sanction easy solutions for problem people' (*Ibid*). Thus, mental illness is perceived more as a term that describes behavioural otherness from the point of view of psychiatry. This view is similar to the social model of disability which argues that disability does not exist in the

individual with physical or mental impairment, but with the general or medical social groups that impose certain strictures or qualities on ways the society identify and segregate the normal from the abnormal; the sane from the insane; and the able from the 'disabled' (Reeve 2004; Barnes and Mercer 2005; Davis 2006).

It is believed that the use of 'mental illness' in the description of the disordered is a non-stigmatising terminology because it evokes meanings of madness in psychiatric or institutional contexts (Harper 2005). Like many other forms of biological illnesses, the supposed reduction in stigma from the use of *mental illness* is premised on the assumption that mental illness is not too different from illnesses of other body parts. Also, Harper argues that the use of the phrase 'mental health problems' is a more stigmatising way of constructing madness. The construction of stigma in the use of 'mental health problem' to describe madness exists in the notion that such usage reifies and labels individuals as problematic. Since such usage is a proposition by psychiatry, stigma in this context is carried out through affixing psychiatric labels to people regarded as socially different, harmful or challenging (Porter 2002). It is believed that 'health' in the use of mental health problems to describe madness, evokes

the presence of a disease, which subsequently suggests that images of mental illness are a fearful contagion (Szasz 1987; Harper 2005, p.462).

Arguably, mental illness and mental health problems are terms that suggest the presence of disease. Invariably, the two terms are based on medical precepts, which mean that the above analysis (suggesting that the use of *mental illness* portend fewer stigmas when compared to the adoption of *mental health problems*) is debateable. Stigma, which ‘refers to bodily signs designed to expose something unusual and bad about the moral status of the signifier’ (Goffman 1963, p.11), may not be directly affected, reduced or increased, by the specific way psychiatry chooses to describe madness, but in the qualities that are signified (symptoms of mental illness) by the signifier (the mentally ill). Since the bodily signs that suggest mental illness or mental health problems - according to psychiatry - are advertised and made known, stigma occur then in the visibility of qualities and characteristics that fall under the various descriptions of madness. Thus, stigma lies in the meanings that descriptive terms evoke in particular contexts. For example, in many social interactions, the term ‘crazy’ has multiple interpretations. Depending on the context in which it is used, the dictionary definition of crazy suggests

usage that ranges from description of the insane, lunatic or demented, overly excited person or even someone experiencing a romantic feeling. Although, mental illness or mental health problem have one dictionary meaning of referring to the mentally disordered or ill, stigma in the usage of these terms is likely to be affected more by the interpretation that is socially attributed to such terms, and the context in which they are used.

On the other hand, 'madness' as a terminology conceptualises images of mental illness in contexts that *exceed* psychiatric discourse (Harper 2005; Cross 2010). According to Foucault in *Madness and Civilisation* (1965), madness is a 'cultural construct that is sustained by a grid of administrative and medico-psychiatric practices (Porter 2002). Historically, madness invoked images of menace and mockery, 'the dizzying unreason of the world, and the feeble ridicule of men at the end of the Middle Ages' (Foucault 1965, p.13). Furthermore, in Gilman's terms (1988), 'madness' is an extreme state of imbalance. Imbalance in this context is interpreted as a state of disruption in mental balance, which was primarily understood from the point of view of the melancholic madwoman in the fifteenth century (Gilman 1988). According to Foucault (2001 in Sapouna 2012),

‘madness’ was part of everyday community life with wide spread perception of the mad as culturally playing a significant societal role during the Middle Ages and Renaissance. In other instances, madness was perceived as a punishment, in early religious myth (Porter 2002).

Similarly, Cross (2010) argues that ‘madness’ is a grass root construction of lunacy, insanity, psychosis, and mental illnesses. He is of the opinion that what was known as madness was advertised in a ‘proliferation of gait, in physiognomy, in weird demeanour and habits’ (*Ibid*, p.2). Also, Gilman (1988) explains that the ‘mad’ were identified by the myths, explanation of the world view held by people, of their external appearances. The external appearances were:

“The sort of images that we conventionally associate with madness; wild unkempt hair, tattered clothing, re-veined staring eyes, muttered imprecations, fists shaken at things that are not there, outspoken dialogue to the different part of oneself are stereotypical conceptions that make it clear how madness is seen.” (Cross 2010, p.131)

Seeing certain images, as explained by Gilman (1988), enables us to ascribe certain qualities as basic identifiable features of mental illness. Thus, how we see signs and

symptoms tell us something about the ‘patient’ – the individual suffering from the illness.

Subsequently, the term ‘insanity’ describes a state where an individual is identified as different and separated from a category of people known as the ‘sane’. In the eighteenth century, insanity had two models: the identification of the insane through physiological shapes of the head; and fixed expressions on the face (Gilman 1988). What is more is that, various models of the insane became a justification for confining the ‘insane’ to asylums: a place popularly known for their prison like features, a situation Foucault (1965) argued was clumsily formulated to fulfil the demands of an industrialized society. Foucault’s position was that ‘confinement merely manifested what madness, in its essence, was: a manifestation of non-being’ (2001, p.109 cited in Sapouna 2012, p.613).

Insanity, madness or mental illness are terms often used interchangeably to establish the presence of certain qualities that evoke perceptions of oddness, difference, or otherness in individuals who assume the role of making informed judgement on the mental state of another, using socially,

scientifically or historically guided knowledge for judgement. In other words, madness encapsulates all possible forms of describing *mental otherness*, all such images that are categorised under crazy, insanity, mental illness, or mental health problems. In his position on how mental illness as a concept is constituted, Cross (2010) argues that signs of madness are recognized from mediated images and representations of mental illness. In this vein, Gilman (1988) argues that the idea that the use of *mental illness* structures both perception of disease and its form appear as a contrast to some assumptions that mental illness is an artefact of the society or biology. The argument here is that the visual stereotype of what madness, mental illness or insanity looks like is activated by constructs of recognisable images of madness. It is for this reason Cross (2010) argues that popular images or notions of the past still feature in present day accounts of mental illness. In this study, the terms *mental illness*, *madness* or *insanity* will be adopted for describing madness from the two main perspectives in this study: science-based methods and the ‘alternative’ or ‘cultural’ conceptions of madness that exist within certain sections of Nigerian society.

1.2 MENTAL ILLNESS IN THE MOVIES

This element of the study focuses on the exploration of textual representation of mental illness, its causes and treatments in the movies, and the significance of these representations to the public understanding of mental health issues in Nigeria. The goal of this research is to provide insights into the ways in which representations of mental illness are reproduced in the media and how particular meanings are circulated (Aina 2004; Atilola and Olayiwola 2011). It has been argued that films, as a form of media, are prominent in the dissemination of information (Atilola and Olayiwola 2011) on subjects of public relevance, and are important aspect of Nigerian culture since broadcast television was established in the country in 1959 (Chioma 2013).

On a general note, the media, which includes; films, radio, print materials, internet services, and books, are employed for information dissemination in many societies. The perceived functions of the media, characteristics of target audiences, and the use value of media messages are structural factors that influence ways in which media messages are constructed and selected by content producers

and media users (Baudry 1975; Mosco 1996). Given the notion that mass media messages and cultural values have a connection (Croteau and Hoynes 2014), the ideological perspectives of media contents may be for a variety of purposes, such as informing, educating, or entertaining (Chioma 2013); influencing social beliefs, attitude or behaviour (Scheufele 1999); or shaping social views for economic gains (Mosco 1996). In relation to media messages as products, ideological perspectives here refer to the underlying images of the society that the media provide. In this study, ideological perspectives of media products focus mostly on the content rather than effect of messages (Croteau and Hoynes 2014) and are discussed in detail in Chapter Six.

Furthermore on the discussion of the perceived function of the media, it has been argued that the media play major roles in promoting improved health systems across the globe (Flora 1989; Newbold and Campos 2011; Uwom and Oloyede 2014). This is crucial to understand as numerous studies show that general health issues (Brodie *et al.* 2001, p.192) and mental illness specifically (Jorm 2000; Birch 2002; Kondo 2008; Demyan 2009; Atilola and Olayiwola 2011a; 2011b) are 'frequently depicted in the mass media, particularly in the entertainment media, and that these depictions tend to be

inaccurate and unfavourable' (Wahl 1992, p. 343). Also, media function as a modifier of thoughts and beliefs of individuals or groups through representations in media texts have been examined in a number of studies (Entman 1993; Scheufele 1999; McQuail 2013). One study argues that the media can be used to shape positive thoughts and ideas around subjects relating to mental health (Demyan 2009), while some other studies argue that the media are often employed to represent negative perceptions or views around mental illness (Philo *et al.* 1996; Cross 2010). It has been theorized that the media constitute a tool for influencing social belief or behaviour through textual meaning making processes found in media representations of objects or subjects. In order to aid the development of a framework for explaining filmic representations of mental health issues in Nigeria, this study will adopt Critical Discourse Analysis as an approach for advocating particular interpretations and explanations of mental health related texts (Chouliaraki and Fairclough 1999) that arise from analyses of movies and interviews.

According to Fairclough (2013, p.4), Critical Discourse Analysis is a 'realist approach which claims that there is a real world including the social world that exist irrespective of

how well we know and understand it'. Thus, discourse is the explanation and interpretation of social life and CDA is a critique of discourse. In this study, (i) CDA will be employed to explain the implication of cinematic narrative structures, with specific reference to the relation of power in semantic representation of mental illness; (ii) absent discourses and the implication of these absences will be analysed; (iii) 'misrepresentations' of mental illness in the movies and perceptions held about mental illness by professionals will be examined and compared; and (iv) an explanation to why movie representations of mental illness in a Nigerian context are the way they are, will be explored. CDA will be used to develop analytical frameworks for explaining why certain strategies or discourses around mental illness and movie texts are emergent and dominant; how the emergence and dominance of some specific discourses constitute social wrong; and how these strategies and discourses (movie texts, interview texts and mental illness) relate in ways that affect social actions. More detailed discussion of CDA is provided in Chapter Six.

Some commonly held views suggest that the movies serve as a conduit for the misrepresentation of mental illness (Wahl 1992; Philo *et al.* 1996; Aina 2004; Gureje *et al.* 2005; Knifton

and Quinn 2008). However, the motive for adopting CDA in this study is further enhanced by the need to analyse the causes, sources and possible forms of resistance that exist in movie representations of mental health issues in Nigeria. Through the use of CDA, it can be argued that representations of mental illness in movies produced in Nigeria are not as negative as argued by some scholars (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011) when analysed from their cultural, social and ideological context (Wodak and Meyer 2001). By way of illustration, reports on misrepresentation of mental health issues in the media (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011) have largely been associated with deviations from science based methods, especially when causes and treatments are not explained from the perspective of psychiatry. However, in this study, dominance in the representation of alternative methods in movies and social settings suggest a shift in paradigm where alternative methods are referred to as negative. In other words, it will be argued in this study that movie representations may not be referred to as 'misrepresenting' an actual condition, when images in the movies are actually reflective of dominant social and cultural beliefs.

Some studies argue that virtually everyone will develop a mental disorder at some point in their lives, or have contact with someone who does (Kessler *et al.* 1994; Jorm 2000). This further explains the importance of critically discussing movie representations of mental health issues. Secker and Platt (1996) argue that the media play a positive part in encouraging attitudes known to be conducive to good health. According to other commentators, as noted above, media representations of mental health issues are largely negative (Philo *et al.* 1996; Clement *et al.* 2013). On one hand for example, judging by the history of journalists who advocate community care, the media have played crucial roles in the development and dissolution of very important public policies on mental health in many countries, especially Britain (Cross 2014). On the other hand, Cross also argues that public policy developers and implementers in Britain, and perhaps in other social settings, may well be influenced and controlled by populist and news agenda setters in the way mental health issues are framed in the media. Therefore, negative or positive representations of mental health issues in the media present the notion that policy makers or implementers and media content producers influence or are themselves influenced by particular representations of mental illness (Secker and Platt 1996; Rose 1998; Harper 2005).

1.3 CONCEPTUALISING PERCEPTIONS OF MOVIE REPRESENTATION OF MENTAL ILLNESS

Mental health care is perceived differently by people from different social groups (Wig 1999; Gureje *et al.* 2005; Abdullahi and Brown 2011; Rashed 2013). Available perceptions of mental health are best categorised into the alternative/cultural mode described in this thesis (religious, magical or spiritual), which is popular among people of African and Asian descent (Fernando 2007); and the science-based (orthodox, bio medical or psychiatry) mental health belief systems. For example, Gureje *et al.* (2005, p.441) argue that ‘poor knowledge of the causes of mental illness, especially attributions to supernatural causation, as well as negative views of persons with mental illness, appear to be common in African communities’, and Nigeria specifically (Adewuya and Makanjuola 2005). This argument is supported by Armiyau (2015), who reports that supernatural beliefs are important components of the knowledge held about mental health among Nigerians. Consequently, representations of mental illness in African and western cultures share similarities in perceptions of what mental illness is or is not, but differs in manifestation. Studies carried out in western cultures refer to negative representations of mental health issues as unrealistic and unfavourable, at those points when

dangerous behaviour is attributed to the mentally ill (Wahl 1992; Rose 1998; Philo *et al.* 1996; Knifton and Quinn 2008). For example, Knifton and Quinn (2008) observed a reduction in media representation of the mentally ill as dangerous in the United States in 1991 (85%) when compared to a similar study that was carried out by Corrigan *et al.* in 2005 (39%) in the same country. However, in the United Kingdom, Philo *et al.* (1996) reported an increased representation of mentally ill as dangerous (60%); and violence as dominant themes in articles analysed over a period of one month. Difference in perceptions of negative media representations of mental health issues in studies carried out in Nigeria show that belief in supernaturalism appear as a more popular 'negative' theme (Aina 2004; Gureje *et al.* 2005; Adewuya and Olayiwoa 2011), thereby suggesting that negative representation of mental health images in the media may not be described as more common in one society than the other, due to peculiar social-cultural factors (Wig 1999; Rashed 2013). Illustratively, negative representation of mental illness in the media evokes different meanings when put in context of the aspect of the representation that is considered negative. Difference in meanings of themes occurs when socio-cultural manifestations and interpretations of symptoms, stigma, causes and treatments of mental illness differ, not just from

one country to another, but from one social group to another, often within the same nation.

Furthermore, this study will argue that the prominence of supernatural beliefs in explanations of causes and treatments of mental illness in Nigeria may persist as an important belief system, over and above formal psychiatry. A report from a historiographical study showed that science-based mental health studies date back to the 1950s in Nigeria (Heaton 2013). The popularity of psychiatry, particularly in European nations, may have started with the adoption of psychoanalysis, which was first introduced by Sigmund Freud in early 1890s (Gilman 1988). Then, science-based mental health care may have attained prominence in most European society in the 16th century onwards due to marginalisation of religion and the subsequent adoption of scientific thinking (Porter 2002; Fernando 2007). Yet, on the other hand, religion is an important aspect of Nigerian culture (Chireau 1997) which impacts largely on ways social issues are conceived and attended to. Contrary to the popularity of psychiatry in western cultures, the cultural importance of religion in Nigeria in the past and present may make absolute adoption of psychiatry a little difficult. The

debate over the relative balance of religion and psychiatry is further explored in Chapter Four.

In sum, studies have shown that mediated images of mental illness impact on people's beliefs and attitudes towards self, society and mental health institutions at large (Wahl 1992; Philo *et al.* 1996; Clement *et al.* 2013). In the bid to explore ways in which media messages may impact on public views regarding mental illness, some studies have examined stigma in relations to mediated messages on mental illness, where stigma is highlighted to majorly constitute images of mental health that are located both in historical and contemporary media types (Morris 2006; Demyan 2009). In this study, the identification and categorisation of themes of stigma in movies become imperative when it is argued that negative representations of mental illness in the mass media contribute towards the negative attitude of the public towards mental illness (Sieff 2003 in Morris 2006). Further exploration of stigma in relation to mental illness appears in Chapter Five.

1.4 SITUATING MENTAL ILLNESS IN MEDIA FORMS

There are different views on what constitutes negative or positive themes in framings of mental health issues in various media forms. Most researches that focused on the representation of mental health issues in media forms such as television, films, documentary, dramas (Philo *et al.* 1996) and publications (Knifton and Quinn 2008; Wahl 2003): newspapers, broadsheets and novels, have highlighted *danger* and *violence* as central themes of mental health in the media (see above). This perception is especially popular in researches carried out in Western countries. Representations of the mentally ill as killers are replete in a wide range of texts (Wahl 1992; Philo *et al.* 1996; Morris 2006), which majorly point to stereotype of mental illness. In addition to portrayals in the media of the mentally ill as killers, Philo *et al.* (1996) argue that images of mental illness in the media can be broken down to violence meted out to self and others. They argued that films such as *Psycho* (Alfred Hitchcock, 1960) have clearly made a deep impression about mental illness on the memories and beliefs of the public. Similar themes of violence will be investigated in this study.

In the interest of explaining how media messages convey negative themes of mental illness, Morris (2006) proposed a model that suggests that the 'characterisation' of the mentally ill in films enhance this process. In this context, the appearance of the mentally ill character is said to convey very strong messages. From a mental health perspective, characterisation involves the adoption of stereotypic images to convey notions that certain individuals are identifiably different through their looks, speeches or behaviour. Morris noted also that an important criticism of film portrayals of mental illness relates to the huge number of misrepresentations and inaccurate messages in the media about mental health in general. Inaccuracies and misrepresentations of mental illness in films are sometimes carried out through erroneous presentations of mental illness in ways that engage and stir the emotions of viewers. This view finds support in the study carried out by Henderson (1996) where it has been suggested that the product of what we see of mental illness is as a result of a complex *negotiation* process. As explained by Henderson (1996), this negotiation process puts media producers, directors or writers in a position where they would prefer to be perceived by audiences as providers of entertainment rather than education. Thus, in the effort to entertain, content producers focus more on

characterising mental illness through the use of themes and images that evoke strong emotions in the audience. Also, Henderson (1996) noted that some drama writers consider research an act that ‘contaminates’ writing. In the analysis offered in this study, content producers have claimed that the need for a story with good narrative pace, and that can as a result maintain audience interest, means that mental health issues are framed in ways that are ‘exciting’. This issue is further analysed in Chapter Eight.

Studies so far have shown that depictions of mental illness are not rare in the mass media nor confined to one medium (Wahl 1992, p.345). For example, it has been argued that newspapers are a more prominent form of media that serve as a source of information about mental health issues (Wahl 2003; Knifton and Quinn 2008). In Wahl (2003, p.1594) ‘newspapers are regarded a primary source of information on various issues, especially mental health, with *danger* taking prominence over themes of *recovery* or *accomplishment*’. The study carried out by Wahl (2003) showed that a large number of people (74% of 1300 respondents) referred to the newspaper as their major source of information on issues associated with psychiatric disorders. In another context, Morris (2006) has identified *misinformation*, *stigmatisation*

and *contradictions* as categories that best explain the portrayal of mental health in the press media. In addition to claims made by Morris (2006), investigation by Knifton and Quinn (2008) into frames of schizophrenia in two selected popular broadsheets in Scotland over a five-year period (2001 – 2005) showed that although attribution to *danger* (26%) was the most common, other themes such as *pity*, *incapability*, *victims* and *blame* also made the list of negative categories. This is possible when there are literally hundreds of mental health articles appearing each year in popular print media (Wahl 2003). In other words, media images of mental illness do exist, and these images can be categorized into positive and negative representations of mental illness. In this study, themes of mental illness in the media have first been analysed by dividing themes into negative and positive categories. Discussion of the positive and negative themes of mental illness emergent in movies produced in Nigeria can be found in sections 8.7.4 and 8.7.5 of Chapter Eight.

The Nigerian academic community has produced few studies that have investigated frames of mental health themes in the media. Results from some of the available studies have shown that the central themes of mental illness in movies produced in Nigeria are *black magic*, *sorcery*, *enchantment*, and

supernaturalism (Aina 2004; Atilola and Olayiwola 2011a; 2011b). These themes are found particularly in explanations of causes and treatment of mental illness. According to Aina (2004, p.23), 'beliefs in black magic and sorcery have dwindled in reality since the embrace of religion (Islam and Christianity) and western civilisation among Nigerians'. The dominance of spiritual or magical themes of mental illness in Nigerian movies suggests a shift from the otherwise prominent themes of danger and violence reported in western media. On another hand, it was reported that a large number (96.5% of a 2040) of Nigerians, drawn from a population of three Yoruba speaking states, perceive the mentally ill as violent (Gureje *et al.* 2005). However, no link has been established between perceptions of violence held among Nigerians to representations of mental illness in the movies, but social beliefs that associate mental illness with violence may not be excused from the possible influence of the media. Since media representations of mental illness in Nigerian movies have been reported to emphasize unprovoked aggression as a common symptom of mental illness (Atilola and Olayiwola 2011a), it is plausible that audiences constantly exposed to images of the mentally ill as characters with unpredictable behaviour may 'cultivate' the perception

that the mentally ill (Gerbner *et al.* 1986) are unpredictable and dangerous (Knifton and Quinn 2008).

Furthermore, the proliferation of movies in a country with an estimated population of over 170 million people that belong to different ethnic, cultural and religious groups has made the need for a media discourse analysis of mental health issues in Nigeria more imperative. In a statistical report by the UNESCO Institute of Statistics (UIS), which can be found on www.uis.unesco.org, the total number of feature films produced in Nigeria between the years 2005 and 2011 was put at 914, 956, 987, 1074, 997 respectively (with no value given for the year 2006). The intensity observed in the production of movies in Nigeria precludes speculations that little may be known about how people seek information about mental health (Jorm 2000). In the absence of empirical evidence to show how information about mental illness in the media represents social beliefs, it can be argued however that knowledge on social issues are transmitted and transferred through the media by communicating social structures and values. Dominant views that suggest that media is a powerful tool for conveying messages to a large and wide, scarcely distributed and heterogeneous audience confer on the media the role of transmitting social values, ideologies and beliefs

(Gamson *et al.* 1992). The adoption of the movies for example, in the transmission or transference of social beliefs may influence a peculiar or reconditioned manner of representing and reproducing images of mental health in the media. This is so because vital components of social groups, such as education, family, language, and relationships, play important roles in the way and manner movie users interact with information contained in films, which consequently impact on the cultural meanings media texts evoke (*ibid*). Also, the ubiquitous nature of movies as a media form is not synonymous with the absolute power of the media in influencing specific attitude towards mental illness. Criticisms of media effect theories have shown that the media cannot be said to have a canonical effect on people, as was often proclaimed in the early 20th century. According to Scheufele (1999), McQuail has summarised media effect models from the turn of the 20th century in four phases. The first phase was the strong effect models that emanated from the influence of the media during the World War 1. The argument of the first phase of media effect theory was that readers of media messages are not cultural dopes who passively read messages as intended by producers (Gamson *et al.* 1992). Audiences were described within this context as active, reflective and selective scanners of media messages.

Also, in the discussion on *framing as a theory of media effect*, Scheufele (1999) has highlighted the importance of operationalising media effect from a *constructionist* perspective. He argues that the media actively engage in providing the frame of reference that audiences use to interpret and discuss social events (further work on the discourse of media influence appears in Chapter Six). In sum, this study is interested in investigating ways media contents present or represent images of mental illness that could be described as reworking existing social beliefs on mental illness.

CHAPTER TWO

BACKGROUND TO THE STUDY

2.0 THE HEALTH SYSTEM IN NIGERIA

The status of the health care system in Nigeria will be the major focus of this section. The health care system in Nigeria is poorly developed in policy, governance and practice (Osain 2011). According to an in-depth explanation provided in the 2009 communiqué of the Nigerian national health conference, it has been shown that lack of coordination; fragmentation of services; dearth of resources including drugs and supplies; inadequate and decaying infrastructures; inequity in resource distribution and access to care; and very deplorable quality of care characterise the ‘poorly developed’ health system in Nigeria (*Ibid*, p. [5]). In addition, recent statistics have shown that many adults between ages 15 and 60 will probably die in Nigeria (Human Mortality Database 2013) from communicable and non-communicable diseases. These communicable and non-communicable diseases are said to be responsible for many deaths recorded in Nigeria. The world health statistics report produced by the World Health Organisation (2009) states that six out of every ten deaths worldwide are due to non-communicable diseases. Although, non-communicable diseases are believed to be more in the

western world (until recently when the prominence of non-communicable diseases were observed in Africa), it is believed that non-communicable diseases are major causes of deaths in Nigeria (Uchendu and Forae 2013). Some of the non-communicable diseases are cardiovascular diseases, cancer and injuries, with HIV disease appearing as the most prominent cause of death, above tuberculosis among communicable diseases (World Health Organization 2009).

Historically, the Nigerian health care system predates the period of colonialism when traditional medicine was the system of health care delivery. 'Traditional healing and medical practices engaged the services of herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons' (Scott-Emuakpor 2010, p.54). Scott-Emuakpor also reported that interaction with modern medicine commenced with European expeditions to Nigeria. The first modern medicine experience in Nigeria was in the treatment of malaria by Dr Baikie in 1854 (*Ibid*). Subsequently, numerous health policies have been developed by the Nigerian government to arrest health challenges that faced the nation as it moved from the era of colonialism to independence. The health policies developed were aimed at making comprehensive and primary health

care services available to both rural and urban settlers. Examples of such policies include: the first and second colonial development plans that were implemented in 1945 – 1962; and the first, second, third and fourth national development plans that were implemented between 1962 and 1985 (*Ibid*). The implementation of the fourth national development plan led to the creation of primary health centres in major parts of Nigeria with the intention of making health care services easily accessible to the rural dwellers (*Ibid*).

In a country with thirty-six states, policies were set to achieve the provision of seven primary health centres, thirty health clinics and at least one comprehensive health centre in each local government area to attend to an estimated 150,000 - 200,000 people (Scott-Emuakpor 2010, p.55). The effectiveness of these policies was not questioned at the point of creation as they seemed promising. However, the present state of health system in Nigeria points to poor implementation of these basic policies. The health system in Nigeria may also be suffering from poor management by government which has the sole responsibility of funding public health facilities (Scott-Emuakpor 2010; Osain 2011). Government funding of health care in Nigeria is measured at

30% of the total health care facility in the country, making the remaining 70% a strictly private enterprise. Today, health care workers go on industrial strikes to protest appalling working conditions within the various health facilities in the country (Scott-Emuakpor 2010). Furthermore, poor health care policy implementation in Nigeria may have contributed to the continued patronage of traditional medicine providers and spiritualists by members of the society who are unable to afford private health facilities that occupy the largest proportion (70%) of available health care facilities in the country (Osain 2011).

In terms of the viability of services provided and policies put in place to make health services affordable to Nigerians, health care system in Nigeria may have taken different shapes after the latest five-year strategic plan of 2004–2008 (Scott-Emuakpor 2010). The National Health Insurance Scheme (NHIS) was initiated to enhance the provision of community based financing scheme for both formal and informal sectors for easier affordability of in-patient, out-patient, maternal and infant care services (Onwujekwe *et al.* 2010).

“Presently, the federal government is responsible for funding and planning health policies in Nigeria through

the Ministry of health, with more states possessing the freedom to develop policies locally and to spend on health system as they deem fit” (Scott-Emuakpor 2010, p.59).

Meanwhile, according to a report from the mental health leadership and advocacy program (MhLAP 2012), funding of mental health in Nigeria attracts only 3.3% of the health budget; the majority of which is pumped into government owned mental facilities. However, unlike general health practices that have attracted a 70% involvement of private investors, mental health care services is yet to enjoy similar involvement in Nigeria. Reasons for poor involvement of private health care providers in the provision of mental health care in Nigeria is worthy of future investigation.

As stated earlier, deterioration in health facilities in the country is attributable to low budgets that have been allocated to the development of health care system since 1981 (mhLAP 2012), an effect of which is evident in the large mortality rate that has been recorded in the country since independence, and the slow reduction in the mortality rate despite the availability of medical experts in Nigeria. In a 2002 data of the Nigerian Medical and Dental Councils, a comparison between available medical practitioners (22,000 registered physicians; 1200 dentists; 62,000 nurses, and

51,000 matrons) to the number in need of medical services (Scott-Emuakpor 2010, p.58) reflect poor presence of medical professionals to attend to the medical needs of Nigerians.

2.1 MENTAL HEALTH CARE IN AFRICA

As discussed in the section above, mental health care appears as a social issue of least concern to policy makers in Africa (Okasha 2002). The negligence of policy makers to formulate policies that will enhance the development of mental health; and the dilapidated state of mental health care facilities support the notion that mental health care is of less importance to policy makers in Nigeria. Knapp et al. (2006) argue that mental health systems in many countries are seriously under-developed, yet mental health problems do not only have huge consequences for quality of life particularly in low and middle income countries, but contribute to continued economic burden and reinforced poverty (Mills 2015). Issues of morbidity and disablement that may arise due to mental illness receive very little attention from the government. Therefore, 'health in general is still a poorly funded area of social service in most African countries and just like other areas of health, mental health services are still poorly developed' (Okasha 2002, p.32).

However, the level of education that members of society are exposed to, may affect the development and implementation of mental health care policies in Africa. Social knowledge of causes and treatment of mental illness is likely to affect individual disposition to mental illness. For example, Ayazi *et al.* (2013) observed in a study sample of 1200 respondents from South Sudan that lower levels of education were positively associated with social distance in mental health. Furthermore, mental health crises in Africa are as a result of social crises such as conflicts and unrest, poverty, poor health facilities and poor social amenities. These social crises may cause Africans to suffer from various forms of mental illnesses without even realizing it. Okasha (2002) also noted that in Africa, it is estimated that 3% of children between ages 0 – 9 suffer from mental disorders, brain disorders and poor psychological development.

2.2 MENTAL HEALTH IN NIGERIA

In this section, the mental health care systems in Nigeria, psychiatric and alternative, are explained. Psychiatric practice in Nigeria may have been significantly influenced by its British colonial history (Ayorinde *et al.* 2004; Heaton 2013a). However, before the advent of the scientific approach

to understanding mental health, treatment of the *mad* or *possessed* persons had been an exclusive practice of the traditional and religious institution (Heaton 2013a). Evidence from previous researches shows that many Nigerians, regardless of their educational and social status, are probably motivated by a supernatural belief system when seeking explanations for causes of mental illness (Aina 2004; Ayorinde *et al.* 2004). The traditional and religious belief system around mental illness impacted on the attitude Nigerians had towards psychiatry during the colonial and post-independence period. In this period, ‘traditional belief remained strong, and healers of mental illness within this etiological constructs were and still remain popular in Nigeria’ (Heaton 2013a, p.132).

Historically, ancient Yoruba tribesmen believed in supernatural and mystical causes of mental illness (Jegede 2005 in Atilola and Olayiwola 2011), which offers a plausible reason why religious and traditional belief system has since remained an integral part of members of the Yoruba social group. However, Heaton (2013a) noted in a historiographical piece that fore runners in the field of ethno-psychiatry acknowledged the role ‘traditional healers’ played in the 1950’s. In turn, this led ethno-psychiatrists to engage in

researches and clinical experiments to determine similarities and differences that exist in Western driven psychotherapies and traditional healing systems in Nigeria.

Psychiatry in Nigeria started under the British rule which provided poorly funded asylums for the colony (Heaton 2013a). Deplorable state of asylums and unwillingness by colonials to fund efforts made at providing mental health facilities similar to those in European countries led to further alienation of most Nigerians from legitimizing the new psychiatric healing system. 'Changes in disposition towards psychiatry began when Lambo Adeoye T. started the Aro Mental Hospital Abeokuta in 1954' (Heaton 2013a, p.31). Before this change began, there were three major asylums built for the confinement of those considered insane in Nigeria. In Mid 1900's, asylums were built in Yaba (a suburb of Lagos) and Calabar (in the south-eastern part of the country) and a third asylum was built in 1946 at Lantoro in Abeokuta (in the western part of Nigeria). These mental institutions were strictly custodial in nature and were provided as a means of keeping those considered dangerous away from other members of society (Heaton 2013a).

However, psychiatric research in Nigeria evolved and was greatly influenced by the work of the Aro village team in Abeokuta. The Aro team, led by Lambo Adeoye, pioneered community epidemiological studies among speakers of the Yoruba language in collaboration with Cornell University in the USA (Leighton *et al.* in Ayonrinde *et al.* 2004). The majority of pioneering Nigerian psychiatrists trained in the UK in the 1960s. In addition, Nigeria was noted as one of the key centres for the landmark International Pilot Study of Schizophrenia (IPSS), a ten-country study of the incidence and manifestations of schizophrenia. An ‘important outcome of this involvement was better prognosis of schizophrenia in Nigeria and other less developed countries’ (Ayonrinde *et al.* 2004, p.536).

In recent times, the bulk of psychiatric service is provided by eight regional psychiatric hospitals and twelve departments of psychiatry in medical schools. A number of general hospitals also provide psychiatric services. Despite the availability of some psychiatric facilities, mental health care remains inadequate, with the ratio of patients to psychiatric beds (0.4 to 10,000 persons) showing depletion in resources. According to one report, ‘there exists one psychologist and social worker to about 100,000 persons’ (World Health Organization 2001

in Ayonrinde *et al.* 2004, p.536). Mental health system in Nigeria is faced with numerous challenges, one of which Knapp *et al.* (2006) argue that it is attributable to ‘unavailability of enough resources in right places or at right times; or allocated appropriately, to meet the mental health needs of the population’. Funding is one of the problems that have been identified as a drawback on development of mental health system in Nigeria. Scarcity of funds appears to be impairing growth of the few mental health care facilities in Nigeria. From observing social trends, a major part of the available fund is expended more on employing mental health care professionals who struggle to attend to patients, who are considered to be a meagre fraction of the totality of people in need of professional mental health care services. This means that paucity of skilled mental health practitioners in low-income countries constitutes a severe resource limitation, ‘a problem exacerbated by the migration of skilled professionals to countries offering better salaries and quality of life’ (*Ibid*, p.165).

Before and after Nigeria gained independence in 1960, the traditional healing system attributed causes of mental illness to different sources than those identified by ethno-psychiatrists (Heaton 2013a). Ethno-psychiatrists expressed

views that suggested that mental illness was characterized by the deviation of Africans from certain norms. Heaton (2013) argues that Africans were perceived by the ethno-psychiatrists as extroverts, communally oriented, unambitious, superstitious, lacking in retrospective insight, or unintelligent. On one hand, 'ethno psychiatrists thought that adherence to African norms contributed to low record of mental illness among Africans' (Heaton 2013, p.48). Thus, detribalization, which is the act of forcing people to adopt the culture of the colonials, formed the basis for explaining causes of mental illness among Africans before and after independence (*Ibid*).

Similarly, in the period after colonialism, traditional causal beliefs of mental illness remained popular among Nigerians as more subjects interpret issues relating to mental illness from religious and cultural perspectives (Ayorinde *et al.* 2004; Gureje *et al.* 2005). From the perspective of 'traditional healers, mental distress was attributed to witchcraft, sorcery, spirit possession, supernatural affliction and violation of taboo' (Heaton 2013a, p.132). Although, Heaton (2013a) did not look independently at how various religious beliefs in Nigeria interacted with the history of psychiatry in the country, major religions in Nigeria (Islam and Christianity)

may have played its own roles in nurturing peculiar beliefs in mental illness because religious practices impact largely on the Nigerian culture (Ayorinde *et al.* 2004).

2.3 HOW GOVERNMENT POLICIES HAVE AFFECTED MENTAL HEALTH IN NIGERIA

Mental health problems have huge consequences for quality of life in low and middle income countries and contribute to continued economic burden and reinforced poverty (Knapp *et al.* 2006). In Nigeria, reports suggest that there are not enough resources to cater for mental health of Nigerians (mhLAP 2012). Evidently, the presence of underdeveloped structures for delivering services; widespread unemployment; individual and national poverty; low national productivity; corruption in public and private systems; unsupportive political priorities; and the ‘unavailability of mental health resources in the right places or at the right times, or allocated appropriately to meet the mental health needs of populations may impact on the general state of mental health system in any country’ (Knapp *et al.* 2006, p.158).

A recent large scale community study in Nigeria has reported that about forty-five of every 1000 persons in the community may have experienced at least one depressive episode in their lifetime, while sixty-five in every 1000 men may have suffered a substance use disorder (Gureje *et al.* 2007, p.42). In the same light, the Institute of Medicine (2001) estimated that about 50% affected persons are reached by mental health services in developed countries and only about 15% are reached in developing countries. Evident in this argument is a dichotomy between expectations and resolutions of international community and efforts and policies put in place by the Nigerian government to abate the detestable condition of mental health facilities in the country. In a resolution made by the World Mental Health (WMH 1995), there was a call on nations to upgrade the quality of mental health services for children and adolescents; develop effective treatment and demand reduction program for substance abuse (Saraceno *et al.* 2007); increase public and professional awareness; and reduce stigma and discrimination (Institute of Medicine 2001). However, Nigeria is yet to fully implement these policies meant for the improvement of mental health care as mandated by World Mental Health (WMH 1995). The current level of funding allocated to health (3.3%) in Nigeria

appears inadequate to meet the health needs of the population (Gureje *et al.* 2007).

The huge burden of disease imposed by mental disorders in rich, low-income and middle-income countries is further explained in the World Health Report (2001). Even in the instance of popularly held views that more than 25% of people from all societies will develop one or more mental or behavioural disorders (World Health Report 2001), it is argued that burden of disease caused by mental disorders may reduce with the adoption of a mixed model of service. According to the World Health Organisation, a mixed model of service is the provision of mental health care to help serve millions of people with mental disorders through primary health and specialized service centres (WHO 2001; Saraceno *et al.* 2007).

However, the implementation of the mixed model of service in the development of science-based mental health services in Nigeria has been slow. The redundancy may be attributable to factors such as poor training and supervision of primary care workers; and poor articulation of a structured and clear link between primary care workers and specialist mental

health professionals (Saraceno *et al.* 2007). A program that aimed at integrating provision of mental health care service at the primary care level and specialized or professional level was formulated as part of the National Mental Health Program and Action Plan (*Ibid*). This program was formally published as a policy document in 1991. By promulgation of this program, mental health became the ninth component of the nation's primary-care service. The program envisaged that mental health services be scaled-up so that essential treatment, including psychotropic medications, is available to those in need in the community. According to the policy document, services are expected to be delivered by trained primary health workers, with coordinated supervision provided by specialist mental health workers (Saraceno *et al.* 2007). However, the program has not had the desired effect on mental health service delivery as reports from research shows that science based services have reached only a minority of those in need.

“Estimates suggest that fewer than 20% of people with mental health problems receive any services. Of those who do receive service, hardly any get adequate treatment, even though research shows that evidence-based interventions can be delivered at affordable costs in the country. The program's laudable goal—to reduce stigma of mental disorders in the community and improve the knowledge and attitude of primary-care workers about mental health—has not been a success.

Most primary-care settings still do not have the basic psychotropic medications that were included in the essential drug list.” (Saraceno *et al.* 2007, p.1169).

In an analysis made by Okasha (2002), the number of science based mental health care professionals drawn from a population of 135 million Nigerians were seventy psychiatrists, fourteen psychologists and 7200 psychiatric nurses. These figures differ largely from the 350 psychiatrists, 4199 psychologists and 7000 psychiatric nurses that were reported in South Africa with a population of 45 million people. Health in general is still a poorly funded area of social service in most African countries and compared to other areas of health, science-based mental health services are also poorly developed (Jorm 2000). Suggestions from Saraceno *et al.* (2007) show that advocacy for science-based mental health services will be more likely to succeed if such is informed by much needed research on factors that shape political will for improvement of mental health services. Success of mental health services may also be reliant on willingness of policy makers to formulate policies that will improve mental health care services in the country.

2.4 TRAVAILS OF MENTAL HEALTH IN NIGERIA

In a report provided by Mental Health Leadership and Advocacy Programme (mhLAP 2012), the prevalence of mental illness was put at 20% of the total population in Nigeria. By implication, in a population of an estimated 170 million people, 34 million people are likely to suffer from various forms and degrees of mental illnesses. Despite the preponderant presence of mental illness, it has been argued that negative perceptions of causes (mhLAP 2012) and treatments exist among the mentally ill and their relatives. Perceived causes of mental illness such as misuse of drugs or causes attributable to the supernatural (Aina 2004) have influenced treatment seeking behaviour of people. Also, reports from Mental Health Leadership and Advocacy Programme (mhLAP 2012) show that many Nigerians with mental illness turn to spiritual or traditional healers for help (Aina 2004; Gureje *et al.* 2005).

From a historical report, cultural beliefs reinforce the view that supports traditional or spiritual causes of mental illness among Nigerians regardless of the age, educational level and religious inclination of a social member (Heaton 2013a). Over the period of 1950–1970, however, a group of trans-cultural

psychiatrists tried to explain the practice of the traditional healers in line with psychoanalytic and psycho-therapeutic theories developed in Euro-American contexts. Heaton (2013a, p.132) reports that the result of this effort led to the description of traditional healing system as 'primitive' in comparison with the psychiatric system, but that the traditional system had a better chance of cultural acceptance than psychiatry.

The growth of psychiatry in Nigeria may be affected by the level of availability of information on the existence or efficacy of psychiatry. A large fraction of Nigerians are presumed to be ignorant of psychiatric explanations of causes and treatments of mental illness (Atilola and Olayiwola 2011). Predominant beliefs and attitude towards mental illness in Nigeria is such that existed before the advent of science: traditional or alternative belief in causes and treatments of mental illness (Gureje *et al.* 2005; Heaton 2013a). Attitudes associated with mental illness among Nigerians are actions of castigating the mentally ill; isolating the mentally ill; and sometimes neglect of people with mental illness (Adewuya and Makanjuola 2005).

From another angle, mild and aggressive presence of stigma towards the mentally ill in Nigeria has been explored (Adewuya and Makanjuola 2005; 2008). Consequently, it can be argued that negative views about people with mental illness exist among Nigerians (Armiyau 2015) and are evident in the level of tolerance people have towards the mentally ill (Gureje *et al.* 2005). However, social structures that enhance the spread of stigma towards the mentally ill in Nigeria are unknown. In western cultures, media sources such as films and news stories about killers suffering from mental illness are considered primary contributors to mental health stigma (Wahl 1992, p.343). Negative views in western media ranged from perceptions of the mentally ill as intellectually retarded; incapable of working at jobs; and constituting a social nuisance. These negative themes and more, as studied in the western media, will be further investigated in ways movies represent mental health themes in Nigeria.

2.5 UNDERSTANDING ATTITUDES TOWARDS MENTAL HEALTH ISSUES

There exist different notions of how we come to interpret certain behaviour as an expression of the qualities of a person with mental illness, and what informs our decision to

act based on that judgment. In this section, factors that affect popular perceptions of mental illness are discussed. Different studies have attempted to measure factors responsible for popularly held views about mental illness (Philo *et al.* 1996; Rüsch *et al.* 2005; Martins *et al.* 2007; Knifton and Quinn 2008; Corrigan *et al.* 2015).

The more common public attitudes about mental health are stereotypes of incompetence; beliefs that the mentally ill are dangerous; attributions of blame; expectations of poor prognosis; negative emotional responses; and desire for social distance (Rose 1998; Abdullah 2011; Clement *et al.* 2013; Sickel *et al.* 2014). Attitudes held towards mental illness are often categorised into the positive and negative attitudes and in many social settings, the attributes mentioned above fall under the negative category. From among the popular attitudes the public may have towards mental illness, the negative ones are often emphasized in research reports (Wahl 1992; Philo *et al.* 1996; Gureje *et al.* 2005; Knifton and Quinn 2008). The argument here is that the prevalence of negative attitudes is premised on ways knowledge of mental health issues are categorised in social settings. However, if available information on mental illness affects either positive or negative attitudes towards mental illness, some of which can

be formed based on seemingly factual views and values of the world (Ciftci 2013), then the power of influence thrives in the social structure that determines which attitude of mental illness is positive or negative and not in the categories themselves.

Some studies claim that the media, as an example of a social structure, have the potential to de-stigmatize as well as to stigmatize (Demyan 2009; Clement *et al.* 2013). The media is able to produce or reinforce stigma in ways that may influence individuals, communities and policy makers through represented images of mental illness (Andreasen 2006; Clement *et al.* 2013). In addition, it has been claimed that media can change perceptions of social norms with change in social norms leading to behavioural changes (Clement *et al.* 2013). However, subtle factors in media communication can influence social behaviour when not necessarily being mediated by conscious choice (Bargh 1996; Gureje *et al.* 2005). By implication, elements in the media as a social structure that enhance changes in behaviour, may not necessarily be found in the more salient images or texts in a media product. This explains why absences are crucial units of analysis in critical discourses of movie representation

of mental health themes. Thus, power relations in media contents are not confined to the dominant themes.

2.6 KNOWLEDGE OF MENTAL ILLNESS

If it is assumed that the kind of information on social issues people possess, will impact on their interpretations and perceptions of such social issues, then attitude towards mental illness in any social setting will be affected by the knowledge social actors have of mental illness. For example, if public knowledge of psychiatry is low, acceptance of professional or bio-medical mental health care will be affected (Jorm 2000). Knowledge, an important aspect of human existence, is formed and shared through interaction with powerful members of the society, lived experiences, media reports or anecdotes (Gamson *et al.* 1992; Brodie *et al.* 2001; Birch 2012; Chioma 2013). The argument here is that media representation of mental illness is an important part of the knowledge that is formed and shared about mental illness. Thus, mental health literacy focuses on how much information on an issue is made available to the public. Literacy here does not refer to the ability to read and write, but the ability to detect mental illnesses and take adequate steps in the right direction to alleviate the sufferings of the

mentally ill. For Jorm (2000), mental health literacy is knowledge and beliefs about mental disorders that aid their recognition, management or prevention. Jorm's argument was that the ability to recognize specific disorders and types of psychological distress, and seek mental health information (*Ibid*, p.396) are aggregates of ways mental health literacy may reduce stigma associated with negative social and media representations of mental illness (Thornton and Wahl, 1996; Brodie *et al.* 2001). However, the view that mental health literacy may enhance reduction in stigmatising representations of mental illness has been suggested (Jorm 2000) but yet to be empirically proven.

Another argument is that socially available information on mental illness varies from one social group to another. One possible factor for this is the level of growth and development psychiatry-based explanations on causes and treatments of mental illness have experienced in different social settings. Psychiatry as a science-based method for treating the mentally ill may have started in Nigeria about the same time it commenced in Europe (Heaton 2013a), but the pace in growth cannot be said to be same for both nations. Empirical evidence to show that the level of literacy among people in Nigeria and Europe differ may not be available, but studies

have shown that manifestation of mental illness is subject to multiple interpretations across cultures (Rose 1998; Wig 1999; Rashed 2013; Islam and Campbell 2014). Some of these interpretations may be scientifically explicable or not, but these interpretations constitute how mental illness is seen and understood by members of these cultures and may inform the attitude members will have towards mental illness. Knowledge formation relies on cultural learning, which is premised on the ability to share cognitive understanding of social happenings through developing knowledge of symbols and beliefs (Rashed 2013). Mental illness may be ubiquitous (Foucault 1965), but differences in the ways in which mental illness is understood across cultures, will make formulating a theory on knowledge of mental illness slightly difficult. Furthermore, information on mental health issues among social members is usually adjudged from the perspective of the dominant view (Wig 1999; Gureje *et al.* 2005; Rashed 2013). Meaning that multiple perceptions of mental illness may reside in a particular social group, but the dominant view often takes centre stage.

Exploring knowledge of mental illness from another perspective shows that provision of information on mental health issues is suffering when compared with efforts put at

providing information for other health related issues such as cancer and HIV (Jorm 2000). In a study carried out in Nigeria, Gureje *et al.* (2005) reports that poor knowledge and negative views of causation of mental illness were common and widespread (96.5% of 2040) among people in the South-Western part of Nigeria. The study reports that people also believe that the mental ill are dangerous because of their violent behaviour. Reports from the same study also suggest that most people would not tolerate basic social contacts with a mentally ill person. However, the study by Gureje *et al.* (2005) did not imply that respondents had absolutely nothing to say when asked if what they know of mental illness was acquired through participation or observation of social events, an aspect that would have enhanced knowledge on how people acquire information about mental illness.

Also, Gureje *et al.* (2005) reported in the same study that less than half of the respondents thought that people with mental illness could be treated outside a hospital or other health facility. This was offered in support of the observation that available knowledge of mental illness was poor. This argument by Gureje *et al.* complements existing notions that most individuals know little about mental illness and its treatments and will likely not seek help from mental health

services (Gelso and McKenzie 1973; Demyan 2006; Gureje *et al.* 2005). Psychiatric or science-based guidelines inform references these studies make to poor knowledge of mental illness. By implication, studies carried out by researchers who argue for the dominance of psychiatry often suggest that the presence of alternative views to psychiatry is indicative of poor knowledge of causes and treatments of mental illness. Hence, information on mental health is often judged from the point of view of psychiatry.

The argument here is that the dominant belief on causes of mental illness people have will affect their choices on treatment options for mental illness. If the dominant information about mental illness in the public domain steers towards scientifically explicable causes of madness, logic suggests that the treatment quest for the mentally ill in such a social setting will be from science-based treatment options. Thus, future research interest should be directed at studying ways deviation in causal-treatment logic explained above can occur in African societies against the backdrop of the kind of information that exist in such social settings; and explain reasons for these deviations.

CHAPTER THREE

MOVIES AND MENTAL ILLNESS

3.0 MEDIA IN THE AFRICAN CONTEXT

In this chapter, discussions on media and mental illness will be advanced by putting these two concepts in different contexts. In this section, however, an overview of the evolution of media in Africa will be briefly discussed to give insight to how this has impacted on African nations. Most African countries were colonies once occupied by different colonial powers before independence. Colonialism brought the print and electronic media to Africa (Kupe 1996). Colonisation affected the growth of African countries through a remarkable revolution in media similar to what was experienced in the global world. The revolution in African media can be further explained in terms of the sophistication of equipment media owners began to use in the production of print and broadcast contents in Africa. In trying to explain the situation of African media further, Kupe (1996, p.115) notes that:

“First, African media systems are very small urban phenomena. A majority of the population in African countries lives in the rural areas. Even in the urban areas the penetration and availability of the media is not uniform.... Most countries have one major national daily whose widest circulation is in the capital city. Second,

when it comes to the print media it is only those who can read and write and have the purchasing power who (*sic*) have access to the limited titles available. Levels of literacy vary from country to country but it is an accurate statement to say that levels of illiteracy are high. Third, African media systems are so undercapitalised that existence is precarious and the mortality of newspapers and magazines is very high”.

From an analysis made in a white paper submitted for the fifth edition of the Tokyo International Conference for African Development (TICAD 2012), Africa was reported to have an average economic growth rate exceeding 5%, and against the background of soaring commodity prices, trade is said to have quadrupled over the last 10 years. At present, Africa is said to be attracting international attention as the continent of hope and opportunity, increasing its presence in the international community as the next economic frontier after Asia. In reality, Africa still faces conflict, poverty, hunger, economic disparities, and other challenges that need immediate attention. Poor availability of health facilities characterise the situation in African countries. By implication, illnesses and ailments that have reduced extensively in other developed countries are still thriving in African nations. One of such illnesses is the scourge of mental illness and the attendant attitude Africans have

towards it. However, under-utilisation of the media for social development in Africa is common. Since it has been argued that print and broadcast media in Africa are used more for its entertainment value than its ability to inform or teach people ways to improve their living standards (Kupe 1996), the emergence of these various forms of media may not have aided development in African nations like it did in western nations. Kupe argues that dominant mainstream media in Africa convey promises of development by politicians with little to show of implementation.

3.1 MOVIES IN NIGERIA (ABOUT NOLLYWOOD)

After providing an overview of media in Africa in the section above, the focus here is to explain the birth and growth of movies as a media form in Nigeria. The emergence of African filmmaking dates back to the early 1960's, during the euphoric years of decolonization (Austen and Saul 2010). However, the production of feature films started in Nigeria in the 1970s, indicating the period after the nation was colonized (Haynes 1995, p.97). Although, before Nigeria got its independence in 1960 and began its own production of feature films:

“the British had a Colonial Film Unit that produced documentaries and propaganda, thereby introducing some cinematic technology and skills into the country, but neither before nor after independence did they give any encouragement to Nigerians to make fictional feature films” (Haynes 1995, p.98).

This probably led to the emergence and growth of Nigerian film making as a promising industry, a growth that was partly influenced by the independence most Nigerian film makers developed in the seventies. The *Kongi Harvest* of 1970, an adapted play of Wole Soyinka, was the first Nigerian fictional feature film ever produced (Haynes 1995). However, English language television series of the 1970’s and 1980’s were also very important contributors to the growth of feature films that represent the stories and culture of the Nigerian people (Haynes 2010).

The term, Nollywood, has been adopted to describe a newer and more commercial driven video film industry in English speaking Africa (Austen and Saul 2010). The name Nollywood came from its Nigerian source, as Bollywood and Hollywood came from Bombay in India and USA respectively. The autonomy and independence that Nigerian film industry developed resulted from the financial negligence it suffered

from the British colonials who refused to sponsor feature films. As expressed by Haynes (1995, p.98):

“One crucial difference between Nigerian cinema and other West African cinema is autonomy and isolation of Nigerian cinema. It has developed with very little influence or participation from outside, (*sic*) and exporting of films is an insignificant aspect”.

Thus, the involvement of western community in the production of feature films in Nigeria was almost non-existent. However, feature or cinematic film productions with poor storylines; incoherent narratives; and poor production values began to proliferate and a once sophisticated and engaged Nigerian cinema began to decline (*ibid*).

3.2 ISSUES IN THE NIGERIAN MOVIE INDUSTRY

Although the quality of film production in Nigeria may have declined, its overwhelming presence, availability and accessibility has inspired discourses on issues that affect its existence. The rendition of storyline in Nollywood films have become cheaper and easier through the use of VCDs, DVDs and the internet. Availability and accessibility of easy to afford VCDs and DVDs have impacted more on the wider reach of Nollywood movies within and outside the country. One of the notions produced by the influx of movies is that it

is indicative of an aspect of the economy that is growing. Evuleocha (2008) argue that Nollywood is the world's third largest movie industry as it produces between 500 and 1000 movies in a year, most of which are produced within very short periods under budgets put at an average of \$15,000. According to Evuleocha (2008), Nollywood is a booming industry that employs thousands of people in a year and may have skyrocketed into a \$250 million annual money making enterprise. In the event of the mitigating effect of piracy in the growing movie industry, Evuleocha (2008) also argues that growth in the industry may be sustained and improved if movie producers and stakeholders key into structural requisite for growth. The argument here is that sustainable growth in the movie industry may occur by adopting stories with affective themes, structures and elements; revival of an otherwise dead cinema culture; sponsorship schemes and other such factors that have contributed to growth in Hollywood and Bollywood.

In Nigerian movies, themes of occult economies and ritual murder (Evuleocha 2008); 'mundane stories that examine philandering; wife or husband snatching; infertility or childlessness; and disputes over legacy or inheritance' are seemingly 'over flogged' narratives (Haynes 2006, p.512).

Also, it has been argued that films produced in Nigeria exploit 'negative tendencies' in Nigerian culture (Haynes 2005). Such 'negative tendencies' include themes such as occultism, cultism, fetishism, witchcraft, devilish spiritualism, uncontrolled tendency for sexual display, bloodiness, incest, violence, and poisoning. Themes bordering on societal and political growth are rarely featured in movie narratives produced in Nigeria (Haynes 2005). However, the popularity of media production of narratives with negative themes is not peculiar to narratives from Nigeria only. In African narratives, themes that emphasize negative aspect of social practises of 'young women who defy local morality codes; African's seeking fortunes abroad; men who sacrifice family members to become wealthy and many more' are replete in feature films (Adejunmobi 2015, p.201). Thus, similarities exist in the narrative themes of feature films produced in Nigeria and the wider context of Africa itself (Haynes 2006; Adejunmobi 2015).

The argument here is that narrative structures of feature films in Nigeria and Africa are constantly reworking formulas and re-formulating conventions of the popular (Akudinobi 2015). Interestingly, reformulated conventions in narrative plots do not appear to have eroded the audiences for these

narratives because rehashed stories with miniature differences in elements are acceptable to audiences. Sometimes, it feels as though you can tell how a story still in the telling will unfold and end. This has led scholars such as Haynes (2006) and Akudinobi (2015) to describe most Nigerian narratives as melodramatic in genre. Haynes (2010, p.106) noted that:

“As the size and undeniable significance of the film industries have grown, many people, film scholars and others, Africans and others – have hovered at the edge of the video phenomenon, repeating the same things over and over: it is a fine thing that Africans have finally managed to create a popular, successful film industry and the film makers must be applauded for doing so, but the films are embarrassing in terms of quality and mentality. The people who repeat these things often do not seem to be able to get past this point, to figure out how to plunge in and do some useful work.”

Continued use of similar themes in the telling of stories that are reflective of the political and moral structures of Nigerian society can only mean two things. It is either because narratives rework themes because these themes describe the Nigerian society at all times and in every clime; or story tellers, producers and movie directors, when explained from the perspective that media messages are produced with the intent to meet the needs of the audience the messages are

created for, are motivated more by the need to sell familiar themes (Mosco 1996).

3.3 CONTEXTUALIZING LANGUAGE IN NIGERIAN MOVIES

Nigeria is a diverse, multi ethnic and multi lingual society with three major languages. The languages are the Hausa, Yoruba and Igbo languages while English language is spoken as the *Lingui Franca* and is a major form of communication in media publications, broadcast programs, interpersonal communication and learning platforms. Films are produced in Nigeria in these different languages. In an analysis given by UNESCO Institute of Statistics (UIS), feature films produced annually into Nigerian film market are in three major languages – Yoruba, Hausa and English with a not too popular fourth – the Bini language. Film productions in English language were few in the early 1970's. Haynes (1995) noted that movies produced then were largely influenced by American action films. According to UNESCO Institute of Statistics, feature films in English language are now the second largest category of films produced. Meanwhile, feature films in the Igbo or Hausa languages were scarcely produced at the point feature films became prominent in Nigeria.

The independence movie makers enjoyed at the birth of feature films production in Nigeria, particularly films in Yoruba language, may have influenced scarce production of movies in Igbo and Hausa languages. Although, some 'Hausa feature films made heavy government sponsorships, perhaps due to the Northern influence of Nigerian politics' (Haynes 1995, p.100). In addition, government sponsorship of feature films in Hausa language may have influenced an impressive growth in the production of Hausa feature films as statistics show that the third largest feature films in the twenty-first century Nigeria are in the Hausa language (UIS-UNESCO Institute of Statistics).

Movies or feature films made in Yoruba language are the largest in production annually in Nigeria with an estimated average annual production of 689 feature films (UIS – UNESCO Institute of Statistic). A possible explanation for this is that Yoruba films did not enjoy the sponsorship of films from the Federal Government, like films produced in the Hausa and English language, which made the producers of feature films in Nigeria autonomous. The making of Yoruba movies started as an independent and autonomous venture and can be traced back to *Ola Balogun*, a veteran film producer, 'who worked with artist using the Yoruba Travelling

Theatre to commence the production of feature films in Yoruba language' (Haynes 1995, p.99). Yoruba films are reported to incorporate elements such as 'music, dance, acrobatics, dramas, and traditional metaphysical/religious beliefs in its narratives from the era of the Yoruba Travelling Theatre' (*Ibid*, p.100). Although, the presence of music, dance and acrobatics in narratives produced in Yoruba language may have waned, traditional metaphysical and religious themes have become popular in a large cross section of feature films produced in Yoruba language (Aina 2004; Atilola and Olayiwola 2011a).

In summary, narratives produced in native languages evoke normative and cultural meanings in people who speak these languages. In other words, it can be argued that production of films in indigenous languages provide a platform for promoting indigenous cultural values. For example, Hollywood movies may generically give off the perception that the stories told are reflective of western culture. Thus, someone who seeks an insight into what the western culture is like can do so from watching a movie. This view may also applicable to other countries where movies are produced in indigenous languages. However, globalisation and colonisation have enhanced the infiltration of western ideas

into cultural values in Nigeria, which means that the authenticity of cultural values projected in movies produced in indigenous languages are now being questioned.

3.4 ‘MADNESS’ OR MENTAL ILLNESS ACROSS CULTURES

Culture is a complicated and contested word because the concept does not represent an entity in an independent object world (Rashed 2013). In other words, culture has multiple meanings and the multiplicity in meaning and usage of culture occurs across different disciplines (Barker 2004; Rashed 2013). Culture represents a signifier that enables distinct and divergent ways of talking about human activity for a variety of purposes (Barker 2004). Cultural beliefs or values are identifiable through shared meanings that enable proper understanding of social situations (Rashed 2013). Culture is crucial in the way people define ‘what is abnormal and deviant, how illness is defined and how and where help is sought’ (Bhugra 2006, p.17). Lauber and Rössler (2007) state that culture influences the way mental illness is conceived, perceived, experienced, recognised, labelled and classified in terms of causes and treatments. In comprehending culture as a concept, Swidler (1986 cited in Gamson *et al.* 1992, p.389)

describes culture 'as a 'tool kit' of symbols, stories, rituals, and world-views, which people use in varying configurations to solve different kinds of problems'.

Report from studies carried out in different climes and cultures have shown that the manifestation of symptoms; prevalence and characteristics of stigma; and perceptions of causes and treatments of mental illness vary across cultures (Aina 2004; Bhugra 2006; Rashed 2013; Islam and Campbell 2014). According Bhugra (2006), cultural identity is crucial to the ways in which symptoms of mental illness are conceived, identified and treated, thereby reiterating the notion that symptoms of mental illness and experiences of diseases vary significantly across cultures. The importance of cultural knowledge and experience of disease was considered in the development of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994) where for example, bizarre delusions or bizarreness as a symptom of schizophrenia was described as been difficult to judge across cultures. In relation to this, Atilola and Olayiwola (2011a) also argue that culture influence mental health attitudes and help seeking behaviour in Nigeria.

A number of studies have explained the ways that conceptions of madness vary across cultures (Wig 1999; Gureje *et al.* 2007; Lauber and Rössler 2007; Barke *et al.* 2011; Islam and Campbell 2014). For example, Wig (1999), in a review of the role of spirituality in the life of an Indian established that Indian belief in mental illness differ from Western theory of body and mind dichotomy. Spirituality is at the core of existence of Indians who practise many of the popular religions of the world: Islam, Christianity, Judaism, Hinduism, Buddhism, Jainism, Sikhism, and Zoroastrianism.

Similarly, in a comparative study of widespread mental health stigma in Western and developing Asian countries, Lauber and Rössler (2007) reported a similarity in perceptions of violence and aggression in the mentally ill. Also, stigma of mental illness has been reported in African societies (Gureje *et al.* 2007; Barke, Nyarko and Klecha 2011). However, the presence of stigma in Western, Asian and African continents does not signal a similarity in the cultural manifestation of stigma. For example, stigma in Southern Ghana has been reported in the social use of the term “headache clinic”. Historically, Headache Clinic referred to the first psychiatric clinic in Ghana and was adopted in order to evade the “taboo” people of Ashanti culture in Southern Ghana ascribed to

mental illness (Barke *et al.* 2011). A similar example can be found in ways geographical areas where mental institutions are located have become terms used to refer to the mentally ill in Nigeria. For example, terms like 'yaba' or 'yaba left' in reference to Federal Neuro-Psychiatric hospital located in Yaba, a province in Lagos; and 'aro' in reference to Neuropsychiatric Hospital located in Aro, a province in Abeokuta, are now been used arbitrarily to refer to bizarre behavioural traits.

Similarity also exists in belief and religious practises associated with mental illness in African and Asian communities. Explanations of causes and treatments of mental illnesses from spiritual, religious and magical perspectives can be found in both continents. This view is contextualised in situations where traditional and science-based help seeking approaches are assembled in resolving distress when encountered by people; with traditional healers enjoying popularity and social acceptance more than psychiatry (Gureje *et al.* 2005; Lauber and Rössler 2007).

Contrary to accounts of stigma in western societies, the mentally ill may be less stigmatised in Arab/Muslim

countries (Lauber and Rössler 2007). Reduced stigma in Muslim communities has been observed in perception of causes of mental illness or insanity sometimes attributed to brain dysfunction or humoral imbalance. To further understand how mental illness is understood in Muslim communities, Islam and Campbell (2014) embarked on a thematic analysis of four English translations of the Muslim religious book, the Holy Quran. The aim was to explore evidences that suggest a connection between spiritual possession and mental disorders or “madness”. The result from Islam and Campbell’s (2014) study show that a common belief in attributing mental illness to jinn-possession in Muslim communities may be linked to a pagan practice that is targeted at taunting and labelling people. Islam and Campbell argue that belief in jinn-possession as causes of madness is deeply entrenched in the ideological framework of Muslim communities. The source of this ideological representation is Islamic religion (the Quran). The argument here is that belief in jinn-possession among Muslims may have led to under-utilisation of main stream mental health care services. Their study suggests that, although madness and possession appeared in contents of the Quran, correlation between mentions of madness in the Quran and jinn-possession was not confirmed. Their study also

demonstrated that association of jinn-possession with madness is a pagan view that is inconsistent with the message of Islam (Islam and Campbell 2014).

However, this led them to argue that stigma associated with mental illness in Muslim communities is multifaceted. Self-stigma becomes apparent in widespread belief that the spiritually weak become mentally ill from the devil's influence. Community/family stigma exists in communities that thrive on evil possession in causal explanations of mental illness. A major limitation to the argument made by Islam and Campbell (2014) on the non-existence of a direct connection between jinn-possession and madness in the Quran, is in the idea that analysis of the content of the Quran is incomplete without reference to the Sunnah, statement and actions of the Prophet of Islam, Muhammad. Within the Muslim community, the Quran and Sunnah are primary sources from where guidance is sourced. For example, the exact way of carrying out some religious rituals such as the performance of the five daily prayers and ritual baths are not directly described in the Quran, but prayers and ritual baths are observed in specific ways across all Muslim communities. This is so because teachings of the Sunnah are as important as contents of the Quran among

Muslims. Thus, the fact that there are no direct references made to jinn-possession and mental illness in the Quran do not discredit belief in jinn-possession as an acceptable cultural interpretation of causes of mental illness in Muslim communities. The argument here is that if jinn-possession exists in Sunnah teachings, then attributing causes of mental illness to jinn-possession has a credible connection to the core values of Muslims.

Furthermore, the prominence of science-based mental health in Western cultures and the inability to scientifically prove efficacy of spiritual or religious beliefs in mental health does not imply that psychiatry is a better option for attending to issues bordering on mental health. In a situation where superiority is attributed to psychiatry over many possible alternative explanations of causes and treatments of mental illness, a steer towards ethnocentrism is observable. According to Wig (1999), ethnocentrism is reflected when psychiatry or spiritual beliefs are promoted as a better belief system over another. Although, Wig (1999) speculated that we may be 'moving towards some kind of merger between spiritual and scientific cultures', especially because the social influence of psychiatry appear to be waning from source: in its conception of diagnosing mental illness; and in its

explanation of why psychiatry is superior to other options (Porter 2002). Illustratively, Wig (1999) argues that psychiatry identified excesses in certain qualities of man as mental disorders by leaving others out. Thus, the criteria for deciding how excesses of some and not all human qualities attract description as mental disorders have been questioned. Excess of anxiety and depression are interesting examples of human qualities that psychiatry has chosen to refer to as mental disorders. On the other hand, excess of human qualities such as greed, lust, or wickedness have been left out as forms of mental disorders. In other words, psychiatry as a science-based guideline for explaining causes and treatments of mental illness may be insufficient to attend to mental health needs across cultures. These lapses that exist in some explanations of mental illness by psychiatry may affect absolute absorption of psychiatry in Asian and African nations, thus the suggestion that psychiatry may need to look at culturally associated practices of mental health in African and Asian nations to improve existing practices of psychiatry (Wig 1999; Fernando 2007). This is so because explanations of mental illness are incomplete without explanations from social and cultural contexts (Agbayani-Siewert, Takeuchi and Pangan 1999)

Although, medicine in its nature suspends belief in the supernatural (Porter 2002), the claim that psychiatry is superior to other options of attending to mental illness is yet to be fully embraced in African and Asian communities as studies show that belief in the supernatural is still prominent in these communities (Wig 1999; Gureje *et al.* 2005; Atilola and Olayiwola 2011a; Islam and Campbell 2014). Although, there may be need for further studies to explore reasons why differences occur in treatment values of psychiatry and alternative methods; and why people prefer to uphold spiritual explanations over psychiatry in African and Asian settings (Heaton 2013a; Islam and Campbell 2014), the presence of ethnocentrism, the view that psychiatry is superior to many other possible explanations of causes and treatments of mental illness, may hinder absolute absorption of psychiatry in African and Western nations (Wig 1999; Fernando 2007).

There is need for further studies to investigate reasons why communities are required to shift from supernaturalism in the conceptualisation of mental illness to psychiatry. If cultures that nurture beliefs in supernatural, spiritual or magical concepts of mental illness are unable or unwilling to shift ground, this may suggest that time is nigh for science to

investigate values from “alternative” mental health care modes that science can integrate into “spiritual psychiatry” (Fernando 2010). In this context, a move towards a merger between spiritual and scientific beliefs in mental illness is been proposed (Wig 1999). Further investigation of how adoption of scientific or alternative mental health interventions in cultures lead to complete or partial remission of mental illness will advance available knowledge on reasons why social groups prefer certain mental health care modes over the other.

3.5 POST MODERNISM AND REPRESENTATIONS OF MENTAL HEALTH ISSUES

From the preceding section, it can be inferred that many attitudes about mental illness have deep cultural roots (Knapp *et al.* 2006), many of which are acquired through shared beliefs, symbols and participation within social contexts (Rashed 2013). Rashed (2013), in a study called *Culture, Salience and Psychiatric Diagnosis*, culture is described as a concept that thrives on cultural learning: a process that involves developing knowledge of symbols and beliefs that enables the sharing of cognitive understanding of social situations. In other words, ‘what we see and not just

how we see it is influenced by culture' (*Ibid*, p.6). If cultural factors are crucial to ways members of social groups conceive of social issues (Subbotsky and Quinteros 2002), changes in culture and education of social members may change the ways social issues are conceived.

Shifts in culture have been enhanced by globalisation, which technological breakthroughs, science and economic advancements have made possible. Philo and Miller (2000) argue that the free market culture erupted from these changes and has since affected television production. Further reports suggest that television prioritised production of contents that will attract popularity over contents that will 'set and lead standards'. The desire for popularity encouraged the commercialization of media content and media struggle for audiences in a highly competitive market (Henderson 1996; Philo and Miller 2000), which may have deepened privatisation of culture (Gamson *et al.* 1992).

Changes that were affected by the way society interacted with emergence of a free market brought about 'post modernism theory'. Post modernism describes ways social structures react to the effect of consumerism or commercialisation. Philo

and Miller (2000) explain that post modernism offers a view of individual as consumers in a sea of images, from where meanings of symbols in the world we live in are constructed. Here, meanings of symbols are construed as the 'truth' of what the world truly represents, which is seen in 'how text, be it a work of art, written text or any moment of language, is interpreted by the cognizing mind of the individual or the 'speech community' (Philo and Miller 2000, p.836). Further explanation by Philo and Miller (2000) on post modernism relates accounts of truth to issues of textual representation, which differ from some other conclusions that the media provide a fragmented and confusing view of the world (Gamson *et al.* 1992). The abandoning of truth and reality in post modernism has led Philo and Miller (2000) to argue that postmodernist have mistakenly understood a series of new responses to free market relationships to mean the emergence of a new type of society. They explained that reality is constituted and negotiated through language. Therefore, truth becomes a function of how texts in language are interpreted by individuals of a community. However, Philo and Miler (2000) argue that language is formed in a world of relationships and objects within a given reality.

In relating post-modernism to representations of mental health in the media, it is argued that generated images of the world in the media are used to construct meanings about political and social issues (Gamson *et al.* 1992). Images and spoken words are examples of texts. Texts are also known as products or producers of meanings that individuals acquire through observation, and employ in the interpretation of social events. Observation as an integral part of the meaning making process enables the generation of meanings when encountering new texts. In other words, new meanings are generated with each new encounter (Philo and Miller 2000) to facilitate instant interpretation of social events. Images in television are an intense site of struggle, influenced by forces such as the desire for popularity; and the influence of an overarching power (Gamson *et al.* 1992; Philo and Miller 2000). Images as mental pictures of something not real or present (Gamson *et al.* 1992), draw attention to textual meanings, observable in structures of text from past or future encounters with similar texts. Thus, meanings of texts may not be static or isolated, but are reproduced in various cultures through constructions of meanings of beliefs and symbols, the media being one of the means through which these meanings are generated and reproduced (Gamson *et al.* 1992). In addition, Gamson *et al.* (1992) argue that the media

are used for symbolic contests among competing sponsors of meaning; and it is in this context that 'systematic representation or misrepresentation of mental health issues matter in contemporary media culture' (Cross 2010, p.29).

In the representation of mental health issues in contemporary popular media, Wahl (1995) in Cross (2010, p.35) argue that 'creative professionals in today's media may be carrying on traditional depictions of the past'. It is believed that many images of mental illness today are repetitions or residuals of long-standing popular beliefs (Gilman 1988; Porter 2002). Cross (2010, p.40) argued that:

“... a pattern of continuity in images of madness that run across history raises definite hermeneutical problems because, ... each historical period has its own understanding of what madness is, how mad folks are to be regarded, what sort of representational identity madness should adopt vis-à-vis the continuity for whom the image(s) of madness signify in the first place”.

Thus, continuity in the way images of mental health reappear in media coverage, Cross (2010) argues, presents mentally ill patients as familiar figures within various social settings.

However, Rose (1998) argues that social representation of madness has not made madness a familiar social issue, simply because it resists safe classification. Rose's argument focused on the notion that 'representations of madness resist safe classification in its emphasis on uncertainty, unpredictability, and lack of semantic or narrative anchors' (Rose 1998, p.216). Thus, continuity or familiarity, as the case maybe, in the representation of madness, depend on ways media technologies, cultural forms and historical consciousness have reacted to changes brought about by commodification of people and human relationships, thus the argument that power and interest structure the society (Foucault 1965; Philo and Miller 2000).

3.6 SELLING MADNESS IN MEDIATED MESSAGES

The media are a business oriented institution that has its output driven by profit and an overarching need to gain and sustain audience interest or attention (Morris 2006). In other words, the political economy of the media describes the commercial environment of media institutions (Seale 2003). Engaging in a study of the commercial environment of media institutions will include examining the impact government policies; professional codes and ethics; and business interest,

have on the production of media content. The argument here is that economics of the media or commercial concerns dictate important elements in media productions (Gamson *et al.* 1992). Television imagery is a site of struggle where the powers that be often compete (Gamson *et al.* 1992). Thus, the nature of media discourse allows plenty of room for social groups to offer competing constructions of reality and to find support for them in readers whose daily lives may lead them to construct meaning in ways that go beyond media imagery (*Ibid*).

Comparatively, Mosco (1996) explains that political economy of the media can be understood from three dynamic processes; ‘commodification’, ‘spatialisation’ and ‘structuration’. Commodification in political economy of communication has been explained by Mosco to represent a process of transforming use values into exchange values; of transforming products whose value is determined by their ability to meet individual and social needs into products whose value is set by what they can bring into the market place (Mosco 1996, p.144). The process of commodification is found in how messages are transformed from bits of data to systems of meaningful thoughts, then finally to sellable or marketable finished products (*ibid*). In the theory of

commodification of media messages, the audience is the primary commodity. Audience needs is also a major factor in the 'negotiating processes' involved in the production of media contents (Henderson 1996).

The political economy of communication can, of course, be understood as the fusion of two salient words – politics and economy. Politics of power and influence of men in the uppermost part of organisational hierarchy are major factors that influence how messages in the media are constructed and the ideology the messages uphold. This is the aspect Mosco (1996) referred to as 'structuration theory' of the political economy. Structuration theory has been described as an 'approach to social life that aim at addressing goal oriented reflexive human actions without giving up on understanding the 'sutures' of power that mutually constitute social actions' (Mosco 1996, p.212). Furthermore, Henderson's (1996) reference to negotiating process of media production share similarity with Mosco's view of structuration.

In issues relating to health, Seale (2003) described political economy as an approach that has to do with the commercial

environment of media institutions. Seale argues that the assumption that media portrayals of health-related issues may be construed as inaccurate is as a result of inadequate understanding of what constitutes the processes of producing media contents. The conditions of media production are such that 'people do not make TV programmes or publish newspapers solely in order to provide the public with accurate health information' (Seale 2003, p.519). Meanwhile, in Henderson's (1996) view, television account of mental illness is a product of a series of negotiations that occur between various structures of the production hierarchy: that is producers, directors, financial sponsors and editors. In order to understand how this affects the portrayal of mental illness in the media, which she already argues are negative and pervasive, Henderson focused on non-news programming in her interview of production personnel over a two-year period. The result showed that what we ultimately see on our television screens are the outcomes of a complex negotiation process. The negotiation process has been proposed to give us an understanding of 'how the media works' (Henderson 1996, p.19). Further explanation suggests that in the process of producing images of mental illness:

‘... writers, journalists and programme-makers work under a series of competing pressures; personal and organizational agenda; constraints of economics; genre;

hierarchy; and the need to attract and maintain audiences' (Henderson 1996, p.19).

Also, Henderson (1996) argues that the need to entertain has led content producers to consider researching a burden that aids the process of making interesting TV drama. The underlining point here is in the interest of producers to create media contents that will 'sell' based on perceptions that audience demand interesting stories. From interviews with different drama writers and producers of TV dramas with mental health themes, producers opine that the audience disapprove of been lectured or educated on social issues by movie producers (*Ibid*). Thus, media representations are influenced by the need to sell ideas, make profit or sustain political interest. This suggests that audience interest and need for 'narrative pace' in storytelling impact on the construction of narratives with mental health themes.

3.7 DEPICTIONS OF MENTAL ILLNESS IN THE ENTERTAINMENT MEDIA

In this chapter, preceding sections have analysed existing studies based on how arguments in these studies fit in to major discussion in the sections. However, in succeeding sections in this chapter, two studies that explore

representation of mental health issues in entertainment media have been analysed.

3.7.1 Owen's Study

Studies that have investigated representations of mental health issues in the entertainment media are few (Philo *et al.* 1996; Owen 2012; Aina 2004; Atilola and Olayiwola 2011a). In the study by Owen (2012), media representations of specific mental disorders such as schizophrenia were explored, while other studies examined depictions of mental illness on a general basis (Philo *et al.* 1996; Atilola and Olayiwola 2011a). Owen's (2012) investigation on the portrayals of mental illness in the entertainment media was aimed at ascertaining the prevalence of stereotype and misinformation about schizophrenia, with a particular focus on English language movies that featured at least one main character with schizophrenia. Owen selected movies that were released for theatrical view between years 1990 and 2010. The result of Owen's (2012) study revealed that delusion, auditory and visual hallucinations were common symptoms of schizophrenia represented in movies. Owen's study also reported that majority of schizophrenics in movies displayed violent behaviour towards themselves and others,

and at other times, characters displayed homicidal behaviour. Psychiatry was largely evoked for explaining causes of mental illness in these movies. In what appeared to be a study that suggests the prominence of science-based explanation of schizophrenia, may be so because the movies featured mentally ill characters that are majorly Caucasian, reference to supernatural themes did not occur in the study. However, alternative causal and treatment modalities are prominent in movies from Nigeria (Aina 2004; Atilola and Olayiwola 2011a).

In critically analysing Owen's study, it is to be noted that directors and producers of movie contents emerge from social settings that inspire story writing. Therefore, the norms, beliefs and symbols that are understood as representations of mental illness within social settings may culturally be transmitted through social learning processes. In social learning processes, social beliefs and symbols of mental illness may be transmitted; and participation of social members may occur through observation of what has come to be known as mental illness (Foucault 1965; Gamson *et al.* 1992; Porter 2002). Hence, if movies present characters in narratives that reflect the life of Caucasians, real life perceptions of what constitute beliefs and knowledge of causes and treatments of mental illness among Caucasians

will relatively take prominence in media representations. This argument is further explained by Owen (2012) in his submission on why themes such as ‘schizophrenia as possessed’ or association of mental illness with the paranormal in popular beliefs among Asians and Africans (Fernando 2010) did not find substance in the analysed contemporary western English movies.

3.7.2 Atilola and Olayiwola’s Study

In a similar examination of frames of mental illness in twenty seven Yoruba movies, Atilola and Olayiwola (2011a) observed that sorcery and enchantment by witches and wizards were causal explanations of mental illness in narratives. Magic and spiritualism were expressed as a commonly depicted treatment option in movies. For Atilola and Olayiwola (2011a), depictions of mental illness in movies are largely ‘unrealistic’ from a psychiatric point of view. The notion that depictions of mental illness are unrealistic is due to the prominence of themes of magic and spiritualism in portrayals of mental illness in Yoruba language movies.

The description of media representations of mental illness as unrealistic may upset adherents of magical and spiritual belief system. It has been argued that magical or spiritual explanations to life events are adopted in order to understand the cause-effect theory of phenomena science is unable to explain and confirm in the real world (Subbotsky 2004). If scientific explanations are unavailable or unconvincing in their approach to explaining causes and suggesting treatments for mental disorders, social members may consider magical explanations of the world more realistic. It is worth noting here that magical belief is also acquired and entrenched in social settings through day to day observation and socialisation of humans (Bieńkowska 2011).

According to Bieńkowska (*Ibid*), magical beliefs coexist with rational belief. Hence, because interpretations of causes and treatments of mental illness are not in tandem with psychiatric guidelines do not equal interpretations that alternative methods are unrealistic. Gilman (1988) ascribed the domination of biological model of psychiatry in the nineteenth century to perceived success of the 'scientific' over 'religious' model. Magical beliefs, though rarely adopted in explanations of causes and treatments of mental illness in movies from Europe or America (Owen 2012), have been

around since ancient Greece (Porter 2002) and can still be found in the art, religion and imagination of the western culture (Subbotsky 2004). Fernando (2010) argues that in many traditions across the world, mental health is understood through spirituality, which is woven into everyday life. He also argues that spiritualism is central to the belief system of many Africans, Asians and pre-Columbians, thus suggesting that 'spiritual psychiatry' can emerge if psychiatry can broaden its base by coming up with paradigms that emerge from interacting with cultures where spiritualism is highly valued.

Summarily, a major criticism of studies that have explored images of madness in movies is with overreliance on verisimilitude as the criteria for judging the acceptability of certain representations of mental illness over others (Harper 2005). In other words, representations of mental illness that emphasise magical or spiritual themes are downgraded when described as 'unrealistic'. Thus, the development of a study on media representation of madness that focuses more on media forms and functions of madness in particular media texts can advance the critique of mediated mental illness (*Ibid*).

CHAPTER FOUR

MORE DISCOURSES ON MEDIA AND MENTAL ILLNESS

4.0 MAGIC AS A CONCEPT

Magic provides the illusion of control over events and is at the root of many traditional beliefs (Bieńkowska 2011). Magic is a cause and affect theory of happenings that people draw upon in the absence of scientifically proven and acceptable explanations of happenings. A special meaning of magic is evident in cognitive realism that a direct impact can be had on the state of reality by means of an object's name, thoughts, wishes, images, and gestures (*Ibid*). For many generations, magic has been practiced by people of different culture and has persisted in African culture where objects of spiritual efficacy and charms are often used (Chireau 1997). Chireau (1997) argues that charms are objects of magical power that Africans use for protection, health and posterity for the individual or community. Magical beliefs are not confined to African nations only. In the 'civilized' world where science is expected to have answers to most questions of human existence, magical thinking still finds its way into the thoughts of people through art, religion and imagination (Subbotsky 2004).

Also, magical thoughts are common among children and also coexist with rational beliefs in adults. This argument was made by Bieńkowska (2011) when a study to determine phraseological units and belief in the causative power of words was carried out among children in Grades 4 – 6 (ages 10 – 13 years). The result showed that more than half of the participants (54%) believed in the possible effect of predictions on the course of future events. This suggests that magical thinking that manifest in stories children are told may be a common phenomenon in late childhood.

However, anthropological studies suggest that belief in magic can also be found in adults (Subbotsky 2004) and the well-educated middle class individuals in Western culture (Subbotsky and Quinteros 2002). Meaning that, because adults are expected to have acquired a level of education that will increase beliefs in science and technology, this does not imply that adults do not possess magical thoughts. For example, Subbotsky and Quinteros (2002) have argued that the western educated still possess magical causal beliefs in a culture where magical causal beliefs appear incompatible with scientific views. Across Africa, elitism has not necessarily changed the magical causal belief people attribute to life incidences such as mental disorders. Magical

interpretations of life incidences appear more convenient for people to scientific explanations due to factors that border on better accessibility of cultural interpretations of events; and notions that the most accessible interpretations, magical beliefs, are reinforced by key social structures like the family and media. In short, magical thinking is considered important for establishing and maintaining relations in many social contexts (Subbotsky 2004).

4.1 TRADITIONAL BELIEF IN PSYCHIATRY

Alternative or magical modes of treating people with mental illnesses are as old as African culture itself. In Africa, alternative explanations of mental illness that draw on notions of magic, spiritualism, or supernaturalism are popular and account for 70% of mental health care Nigerians seek (Ayorinde *et al.* 2004). The adoption of alternative mode of explaining causes and treatments of mental disorders in Nigeria pre-dates written records (Ayorinde *et al.* 2004; Omonzejele 2004). Reports suggest that traditionalist or ‘occult specialists made use of natural materials, believed to be endowed with spiritual efficacy’, (Chireau 1997, p.237) for diagnosis and treatment of diseases. The use of natural or created objects as vessels of the supernatural (Subbotsky and

Quinteros 2002) exists throughout Western and Central Africa (Chireau 1997). The widespread appeal of traditional beliefs is attested to by numerous accounts that suggest use of conjuring relics, supernatural rituals and occult specialists (Chireau 1997) in attending to diseases in these cultures. Magical causal belief encapsulates strong beliefs that an individual's wellbeing can be influenced through subtle manipulation of agents such as ancestral spirits, sorcerers and diviners that constitute his or her psychosocial environment (Aina 2004). This belief dwells on the notion that manipulations are carried out using natural substances such as leaves, bark and organic essences, many of which are named as sacred figures and objects (Chireau 1997).

In ancient Greece, traditional belief thrived on views that the *oracle* could see the future; and that sacrifices made of animals to gods affected a number of important part of human existence such as the weather type and growth of crops (Subbotsky 2004). Similarly, 'Greek myths and epics held views that madness could occur from visitation by gods, spirits or that health could be restored through divine intervention' (Porter 2002, p.34). In African traditional belief, traditional healers have been reported to use divination to unearth mental and psychological problems in patients

(Omonzejele 2004). In brief, magic, divine interventions, conjuring relics, supernatural rituals and ancestral spirits feature more as qualities that aid the conceptualisation of alternative/traditional beliefs.

However, it may not be impossible that one can observe similarities in the differences that exist between traditional/alternative and science-based mental health care forms. For example, these two forms of mental health care agree that the inability of an individual to interact well environmentally, socially and physically constitute signs of mental illness. On the other hand, a clear point of dissent is observable in the notion African traditionalists hold. In African traditional belief, mental disorders could also be caused by spell casting and evil machinations, a belief psychiatry will strongly oppose in the absence of scientific proof. Illustratively, in Nigeria, mental health care services are largely (approximately 70%) delivered through unorthodox means such as religious organizations and traditional healers (Ayorinde *et al.* 2004).

According to Ozekhome (1990), it is common in Africa to believe that forces such as witches, wizards, sorcerers and

demons can cause brain disorders. Traditional/alternative concept of disease and medicine is the foundation of health care in Africa. In Africa, medicine unlike what can be found in Western culture, are believed to have its own personality and potent living force (Little 1954 in Omonzejele 2004). Hence, management of mental illness by African traditional healers is radically different from what obtains in western therapies and procedures, but not totally ineffective. Meaning that we must be careful not to assume that it is only 'western' technologies and interventions that offer effective ways to prevent or treat mental illness (McKenzie *et al.* 2004; Knapp *et al.* 2007).

Mental illness, like all other interpretations given to causes of unpleasant happenings in African context, is attributed majorly to magical causes. Treatments for ailments among Africans are sought majorly through consultation of a supernatural power that is required to have answers to situations before visits to medical experts are considered. This is because 'magical thinking is evident in situations that involve threats to personal welfare beyond human subconscious' (Subbotsky 2004, p.338). In addition, Okasha (2002) argues that traditional healers pose a challenge to the growth of psychiatry in African countries. It is believed that

traditional/alternative mental health care may advocate strongly against medication intake, thereby constituting an obstacle rather than an asset to mental health care provision.

According to Gureje *et al.* (2005, p.440), the prominence of the supernatural view of the origin of mental illness may imply that science-based mental health care is futile and that help is more likely to be obtained from spiritualists and traditional healers. Such views are likely to have important ramifications for seeking help from psychiatry. In Nigeria, it has been reported that a lot of people with mental disorders had previously consulted a traditional healer before consulting a general practitioner or psychiatrist (Atilola and Olayiwola 2011a). One reason for this may be because 'mental health service is predominantly delivered through unorthodox means such as religious organizations and traditional healers' (Ayorinde *et al.* 2004, p.537). Another reason may be that since psychiatric centres in Nigeria attract stigma (see section 3.5) more patronage of traditional/alternative treatment centres may be attributable to reduced stigma that are socially attributed to these centres. For example, among Yoruba Nigerians, adherents of preternatural belief in causes of mental illness (Aina 2004; Gureje *et al.* 2005) may feel less stigmatized (Wen, Jou and

Yang 1992 in Atilola and Olayiwola 2011) because empathy is usually drawn upon when social happenings are explained from supernatural view point.

Meanwhile, traditional therapists who provide mental health interventions do possess the ability to recognize symptoms of severe mental illness. Although further research into the structural component of traditional alternative mental health services and their implications for psychiatry is important, it is argued here that belief in supernatural explanations of causes and treatments of mental illness may persist, not just because a few individuals hold these views, but because they represent a dominant view in cultures where supernatural belief exists. Subbotsky (2004) may have argued that studies on clinical aspects of magical thinking provide insights into the nature of hallucinatory disorder, and that a borderline on socially healthy perceptions in magical thinking exists. However, knowledge of how to identify where and when the borderline is crossed depend on ability to scientifically explain how magical thinking and manipulations work in reality, thus the need for further study to advance knowledge on structural components of traditional/alternatives modes of treating mental illness.

4.2 RELIGIOUS/SPIRITUAL BELIEFS IN PSYCHIATRY

Religion is important for interpreting and representing reality in African communities. In Nigeria, there are three major religious beliefs. They are Islam, Christianity and Traditional religion (mhLAP 2012). Among the three main religions, Islam predominates in the northern part; and Christianity predominates in the southern part of Nigeria. Also, religious practices are a major component of culture in Nigeria. According to Chireau (1997, p.227), in western and central African regions, religion is not a distinct compartmentalized sphere of activity, but a way of life within which all social structures, institutions and relationships are rooted. In other words, spirituality is integral to knowledge for Africans.

Traditional African religions are oriented towards invocation of powerful 'forces for various purposes, including predictions of the future, explanation of the unknown and control of nature, persons and events' (*Ibid*, p.227). Traditional African religion may be better understood in the way early Christianity, as a form of spiritualism, attribute supernatural events to God (Bever 2009). For many Africans, illness comes from the devil, and in cases where illnesses are attributed to

casted spells or bad fortune, the services of a conjurer or traditional healer is engaged (Chireau 1997).

4.3 THE CENTRALITY OF SUPERNATURALISM IN RELATION TO MENTAL ILLNESS

Beliefs in metaphysical forces are represented in different ways and are central to supernatural beliefs. It is a common belief that metaphysical forces can unearth happenings in spiritual and mundane affairs. In popular discourses, concepts such as ‘occultism’, ‘conjure’, ‘magic’, ‘religion’ and ‘spirituality’ are usually drawn upon to contextualise supernaturalism. In day to day existence and socialization of humans, it has become easy for people to believe that words and manipulation of objects can indeed influence physical happenings around them (Bieńkowska 2011). In other words, supernaturalism, a concept that encapsulates notions of magic and religion, embodies perspectives that rely on metaphysical forces (Chireau 1997). The nature of human existence may be full of magical thinking. For some:

“Magic gives a helpful hand in the circumstances that are beyond rational control ... for those who believe in God, prayer stands for magic and for those who do not, belief in magic and supernatural is the only way to establish and maintain hope.” (Subbotsky 2004, p.339)

In the African setting, conjure is an occult practice that applies to an extensive area of magic, which represent views that healing, spells and supernatural objects can cure or inflict harm on others (Chireau 1997). African priests, those who engage in supernaturalism, are specialists trained to access the supernatural utilizing sacred charms; engaging in ritual discourse with divinities and ancestors; and receiving revelations (*Ibid*, p.227). Conversely, Europeans may have emphasized different forms of belief in the metaphysical through notions of witchcraft; concern about harmful magic; and elite concern about diabolism (Bever 2009). Thus, Subbotsky and Quinteros (2002) argue that differences that occur in traditional, western and logical interpretations of life incidences are not in the cognitive structures of these ways of thinking, but in the way these cognitive structures are applied to different realities and contexts.

Differences that may occur in application of cognitive structures to interpretation of life realities can be found in western and African cultures that support and maintain magical beliefs that important social edifices such as family, culture and the media reinforce (Subbotsky 2004). For example, magical themes are replete in stories of western origin like *Beauty and the Beast* and *Snow White and the*

Seven Dwarfs. Magical themes in western cultural tales can also be found in stories of Santa Claus, Fairy God Mothers, the Easter Bunny, and the Tooth Fairy (*Ibid*) that the parents and media promote. Fairy tales are largely themed around magic and how it can be put to good or bad use. The argument here is that magical themes in these stories remain with children and adults regardless of the education or scientific knowledge that they may have been predisposed to for explaining life incidences.

In the African context, magic is entrenched in the cultural beliefs that transcend religion and norms. In Nigeria, Christianity, Islam and Traditional beliefs revolve round belief in some mystic powers that can make things happen. For Africans, magic and occult beliefs were profoundly shaped by the religious worlds in which Africans had lived (Chireau 1997, p.226). These beliefs have been culturally transferred through media such as religious teachings; folklore relayed to children by parents; and narratives contained in popular media. For instance, the Big Bang theory provides a scientific explanation on how humans came in to existence. This form of knowledge will only be relevant to the scientifically inclined who believe in its argument. Some educated believers in metaphysical powers have chosen to retain unprecedented

conviction in supernatural interpretations on how earth and humans came to be, which for some is experienced in the magical charge felt when spiritual rituals are engaged in. In other words, belief in metaphysical origin of existence has enabled the interpretation of many life incidences, including causal and treatment modalities people adopt in interpreting mental disorders.

Contemporary psychotherapy, which is popularly known as a component of psychiatry, use techniques (Subbotsky 2004) similar to those developed by magic and religion; thus, querying the claim that religious, spiritual and metaphysical thinking may have been excluded from the practice of conventional medicine (Rowbottom 2012). Meanwhile, spiritual, supernatural or magical beliefs are still evoked by people in everyday dealings with social happenings. In addition, irrespective of the educational and social status of many Nigerians, belief in culturally based explanation of causes and treatments of mental illness, influenced more by alternative/traditional interpretations of mental disorders, still exist (Morankiyo and Akinwowo 1981; Odejide *et al.* 1989; Atilola and Olayiwola 2011).

4.4 ISSUES OF IDENTITY IN MENTAL HEALTH

Identity is essential in understanding the ways mental illness is conceived and understood. As suggested in preceding sections, variance in cultural representation and interpretation of mental health issues has provoked deeper thinking on ways general demeanour towards mental illness is affected by identity. Knowledge on issues of identity have been advanced by some studies that explored ways racial and ethnic identities buffer stress of perceived discrimination towards the mentally ill (Mossakowski 2003; Umaña-Taylor and Updegraff 2007) or impact on mental health outcomes through religious identity (Ellison et al. 2013). In this study, identity in mental health has been explained further using social identity theory.

Social identity (SI) can be described as the self-structure of individuals who are defined by categorical membership; character of intergroup relation; and relationship of the individual to a broader social structure (Capozza and Brown 2000). Social identity is concerned with group membership. Positive social identity is achieved and maintained by members of a social group in order to boost self-esteem of the individuals or group, a status derivable from favourable

comparisons with in-group and relevant out-group (Brown 2000). For Brown (2000), social identity can be understood from positions of in-group bias; responses to status of inequality; intra-group homogeneity and stereotyping; and changing of intra-group attitudes through contact. Social identity embraces the view that relationship between individuals and groups can be bridged (Capozza and Brown 2000).

According to Fisher *et al.* (2014), social identity is a psychological adjustment that is influenced by decisions made regarding one's identity in social context. As an illustration, in a study of identity development of multiracial adolescents in schools for multiracial students, *Fisher et al.* (2014) explored the relationship that exist between basic elements of ethnic identities; its components (affirmation and exploration); and mental health outcomes (anxiety, depressive symptoms). The findings from Fisher *et al.* (2014) suggest that multiracial youth may have higher levels of mental health issues than mono-racial adolescents. In addition, multiracial and Caucasian youths were reported to have similar level of anxiety, but had a significantly higher level of anxiety to African-Americans. In this context, multiracial groups refer to a heterogeneous group of individuals with a

combination of racial and ethnic identities. For Fisher *et al.* (2014), this analysis identifies the importance of social psychology and development in conceptualising ethnic identity.

The study by Fisher *et al.* (2014) has facilitated the establishment of a relationship between social identity and mental health issues. By way of illustration, categories of groups that affect or are affected by mental health issues can be distributed into: sufferers, policy makers, mental health users, family of mental health users, mental health providers, observers (who do not have first-hand experience on mental health but rely on media representations or cultural beliefs) and media representations. Within these categories are smaller units of people whose identity are defined by the cultural, economic, ethnic/racial or religious interest they uphold. As identified by Fisher *et al.* (2014), exploration and affirmation are very important components that individuals deploy to integrate into social groups. Exploration is described within the context of social identity as the process of learning about one's ethnic, cultural, religious or economic group. Observing a similarity in the beliefs of an individual around a social issue and the values of a social group may

influence the individual's association or identification with this social group.

Exploration and affirmation are processes required for affirming what it means to be a member of a social group and are significantly related to mental health issues (*Ibid*). According to Fisher *et al.* (2014), members of multiracial groups suffer from mental illnesses more than youths that belong to mono-racial groups, like Caucasian and African Americans. This may be attributable to the psychological stress that members of multiracial groups are presumed to experience as they constantly negotiate between two different ethnic identities. The role of identity and how it affects ways members of certain social group feel about the reputation of their group has been explained from the positions of in-group bias; responses to status inequality; intra group homogeneity and stereotyping; and changing of intra group attitude through contact with other social groups (Brown 2000).

However, Mossakowski's (2003) study of ethnic identity in relation to mental health found that ethnic identity buffers the stress of perceived discrimination and has an association with lower depressive symptoms. Ethnic identity was

explained as requiring committing oneself to racial/ethnic group. Further explanation from Mossakowski's (2003) study suggest that learning about the belief and values of an ethnic group and identifying with the cultural heritage or values of such group enhance quick assimilation into such racial/ethnic groups. The ease of assimilation and comfort that arise from being an accepted member may be contributory to the positive impact racial identification reportedly (Mossakowski 2003) has on reduced expressions or perceptions of discrimination towards the mentally ill. Thus, racial or ethnic identity; taking pride in ethnic practises; active participation in ethnic activities; and commitment to ethnic/racial cultural heritage have been reported to reduce discrimination towards mental health.

A similar study that suggests that identity may enhance reduction in mental health discrimination can be found in the works of Umaña-Taylor and Updegraff (2007). On one hand, Mossakowski used the Filipinos as the study sample for his work while Umaña-Taylor and Updegraff examined Latino adolescents. In an attempt to find out how psycho-social functioning (self-esteem and depressive symptoms) of group members are affected by culturally relevant stressors and experiences (ethnic identity processes, cultural orientations),

Umaña-Taylor and Updegraff (2007) report that ethnic identity exploration and resolution positively predicted self-esteem in members of Latino ethnic group in America. Self-esteem partially mediated the relationship between perceived discrimination and depressive symptoms in adolescents, while positive self-concepts (self-esteem and ethnic identity) were found to minimize negative effect of risks associated with perceived discrimination. Self-esteem was found to be negatively associated with perceived discrimination, but positively associated with the mental health of Latino adolescents.

This is not to say that all forms of social identities lead to improved mental health. Another identity related argument in Ellison *et al.* (2013) suggests that religious identities have negative impact on mental health. The focus of their study was to investigate the link between mental health outcomes and religious/spiritual factors within a social group. The strength of the influence religious identity has on mental health outcomes was found in what was described as “spiritual struggles”, which was reported to have a link with undesirable mental health outcomes. The study on spiritual struggles as a negative aspect of religious identity show that religious identity may yield undesirable psychosocial

outcomes, while other aspects of religious identity such as religious participation, belief, and experience may be associated with desirable psycho-social outcomes that include a reduced level of anxiety and depression (Ellison *et al.* 2013). Social struggles can be intra physic: emerging as a result of a perceived relationship between man and God that appears not to be working out; or based on an unpleasant relationship between members of the same religious group. Thus, effects of religious or spiritual struggles may be reflected in poor mental health outcomes that arise from the intra physic struggle an individual suffers in specific religious contexts.

As explained by Ellison *et al.* (2013), persons struggling with beliefs may lack the ability to cope with life challenges that occur from religious doubt, a situation that may attract stigmatisation and discrimination. Stigmatisation or discrimination that results from having religious doubts may be further explained as in-group bias. Brown (2000) explained in social identity terms that the willingness to prove that a religious belief is superior to others lead to inner and outer group tensions. The inner group tension may be explained in terms of internal or individual struggles with the belief, value and culture of a social group. The inability to live

with an assumed difficulty that may arise from seceding from a social group may force members to remain in such groups, despite experiencing displeasure in the social practise of such groups. The fear of discrimination, stigma or outright condemnation by alternative social groups, despite apparent affinity for the structural belief of such new groups by an individual member, may lead to inner struggles that have implication for mental health outcomes.

Outer tensions between social groups - minority and majority social groups – occur with the assumption that bias between inter groups occur because there is an ascription to superiority or inferiority among the groups. According to Brown, this is known as status inequality. Brown's (2000) explanation on how status inequality affects social identity is in the assumption that positive distinctiveness that are attributable to one social group over the other occurs when inter group bias exist between superior and inferior social groups. Inter group relations or bias in its most obvious area of application can be found in groups where dispute can be observed towards other groups. In mental health, exploration process in social group formation will be reflected in investigating and adopting a mental health care mode that is similar to the existing belief of an individual on causes and

treatments of mental illness. Social identity is then formed based on the group's understanding of mental health, even in instances where social groups with conflicting beliefs about mental health forms inform the creation of identity for minority or majority groups. Developing a strong social identity gives members of a social group the belief in being protected against dangers that lurk in external groups. The damaging and detrimental actions of one group to another could appear in the form of domination, which could be described as an attempt to make sure that the belief and values of one social group overwhelms or completely annihilates that of a minority group (Brown 2000).

A further explanation on how social identity works is evident in the ways the membership of respected and favoured groups boost the self-esteem of members. Alternatively, positive identity is derived from favourable comparisons made between components of in-groups and out-groups (*Ibid*). For Brown (2000), in-group bias is evident in how different groups strive to prove that their group is superior to others. The willingness to prove this leads to behavioural discriminations between groups. In mental health, the superiority of psychiatry is suggested over alternative interventions (magical or spiritual) largely by psychiatric

groups (Porter 2002). For example, in a western society where belief in science-based mental health explanations on causes and treatments are common, sub-sets of science-based mental health social groups will constantly strive to explain why alternative (magical, spiritual or traditional) methods are not suitable options for the treatment of mental illness. Large numbers of texts that investigate and explore the popularity and potency of psychiatry with little study on alternative study, show how psychiatry imposes itself as the better theory for the explanation of mental health issues. However, the prevalence of more narratives and theories supporting the use of psychiatry has enhanced the positive distinctiveness that science based mental health enjoy, particularly in the western world where the development of psychiatry started (Brown 2000; Porter 2002).

4.5 METAPHORS OF THE MOVIES

Images in television are different from other forms of signification (still photography, written texts or artworks) through the use of the movie camera that employs mechanical instrumentation to register series of images (Baudry 1975). The creation of images for the signification of specific meanings from the point of view of content producers

to consumers (audience) has attracted the development of theories to enhance the understanding of media text. The metaphors of the media in this study will involve the exploration of growth and changes in paradigms of media audience; ideological implication of media texts; and dynamism involved in the production of media messages.

The importance of the audience is reflected in the importance of creating media texts in the first place. However, the view that audience interpretation of intended meanings in communicated texts is difficult to ascertain may have led to the development of models to explain ways media messages are received by the audience. As explained by McQuail (2013), earliest model of media audience perceived receivers of media messages as passive and at the receiving end of a linear process of communication, thus the media effect model. This model emphasizes the view that messages are directed to particular audiences with no expectation for feedback (McQuail 2013). However, except in instances where a study is carried out to evaluate the reception processes and reactions emanating from exposure to media messages, reactions to texts in many media forms still fall in this category of model of communication. Media forms, like the print and television, are still evolving in the area of ensuring

immediate feedback mechanism. Furthermore, new age telecommunication devices such as the internet, may have facilitated instantaneous reaction to media texts by audiences who in this situation are still not clear cut (McQuail 2013).

The use of the term 'audience' to describe a set of receivers or decoders of media messages in canonical context has evolved with the change in the way messages are now communicated using newly improved communication systems. McQuail (2013) argues that the audience, as a group of spectators/listeners in the pre-mass media days of dominant effect of media messages, can no longer be used as a benchmark for describing the variety of activities and groups that it is meant to represent. This may be due to the suggestion that media are not static but changing and evolving. The 'mass' concept of communication has been subdued and the concept of media abundance has been adopted in the wake of media overlap and proliferation. This may have led to the disintegration of media audiences into: consumers of certain brands of contents; market for technology that enhances the possibility of a media audience; social or cultural group that are patterned to prefer certain media messages over others; and amusement/leisure users of the media (McQuail 2013).

Researchers have adopted critical, empirical and cultural ways in operationalising 'audience' as a concept (Baudry 1975; Gerbner *et al.* 1986; Schuefele 1999; McQuail 2013). Analysing media audience from the critical perspective implies that the audience is seen as users of media texts for ideological manipulation and subversion (McQuail 2013). Ideological manipulation of audiences using a cinematic product is easy to determine if the consumption of media texts bring about a knowledge effect that can be systematically analysed (Baudry 1975). Ideological characteristics of media texts exist in implicit or explicit terms (Price 2005), and are in some instances perceived as presenting views of a dominant group to a less powerful social group with the intent to influence (mainly the audience).

However, television, movies or the cinema are centralised forms of storytelling that function as an integral part of a dynamic process (Gerbner *et al.* 1986). The dynamism involved in the production of media messages brings about the notion that media messages are created to fit into or 'exploit and sustain the needs, values and ideologies' of the audience (Gerbner *et al.* 1986). It is believed that images, sounds, language, and meanings presented in contents of

cinematic products are not created without particular interest. The purposes or functions that underline the creation of media messages, either to satisfy institutional needs and objectives (Gerbner *et al.* 1986) or to develop and crystallise public perceptions on issues (Scheufele 1999), are crucial to understanding how images in the media are construed and interpreted as constructing social reality. However, it may be argued that in the joining of shots and sequences in cinematic representations, the focus is more on the preservation of narrative continuity, and in the retention of meanings that the images are constituted to represent (Baudry 1975). The interest is usually to maintain narrative unity in films that will have meaning to both the producers and receivers. In other words, influences and effects films have as finished products suffer limitations in perceptions that media messages are constructions of social reality (*Ibid*).

A limitation to conceptualising media narratives as construction of human realities can be better understood when images in films are metaphorically likened to myth. Films are a common proponent in the representation of mythic ideas. Identifying certain representations in media content as mythic emerged from the fact that myths are creations of individuals who reside in a social setting (Levi –

Strauss 1981). Mythic ideas represent the origins of societies; reasons for cultural beliefs; and the provision of explanation for comprehending social, cultural and mental composition of generations. However, myths are regarded as non-instructive about the 'order of the world, the nature of reality, or the origin and destiny of mankind' (*Ibid*, p.66). Structurally, the difference between myth and film narratives can be found in the technical requirement of film production. However, myths and films require the management of images (in films) or language texts (in oral narration of myth) to create meanings. Thus, if myths are reproduced as film narratives, further enquiry will require the exploration of ways these representations explain social happenings or reflect social reality?

4.6 PERSPECTIVES IN MADNESS AND ART

The focus of this section is to contextualize madness in art as a media form. Since the focus of this study is to explain madness from as many perspectives as possible, this section will aim to establish relations with existing perceptions of madness, and art as a media form. Madness and art can be understood from different perspectives, one of which is the historical relations madness and art share. Also, perceptions

that madness resides in products of art exist, so also is the mad and genius debate (Porter 2002). The ‘madness and genius debate’ introduces a similar perspective for explaining madness and art, which is that art constitutes a major form of media that has enhanced the production and reproduction of images of madness or melancholy as we have come to know it (Foucault 1965; Gilman 1988; Porter 2002; Cross 2010).

“What if I were to embrace my madness, to embrace it wholly? I have acknowledged that it guides my art; how about embracing my mad self?...Doing so would be like taking the oil paint that I live and dipping my fingers into those great blobs of pigment, smearing them along a pristine canvas, and then from the canvas across the white walls.... How delicious and free! I say, this is the soul of art making!” (Caughney 2011).

The source cited above is a personal account of a health service worker who was hospitalised for schizophrenia after more than eleven years of previous hospitalisations. From the personal account quoted above, it is suggested that art is a medium of expression that individuals employ to communicate own perceptions on subjects, objects and situations. In this context, it is also argued that art has a relationship with genius and madness (Porter 2002). In Western thoughts, being a genius can be constructed as

being an artist whose connection with unreason and madness inspires creativity found in art works (Lavis 2005). The connection between madness and art in this western concept of artistic activity relates to the view that madness arises from interplay of inner and outer forces. Inner and outer forces here are reasonable and unreasonable factors that inspire notions of disease and madness similar to those of muse in art production (Lavis 2005). By implication, creativity expressed in images of art emerges from inner turmoil in creators of art. In addition, it has been argued that ‘true art’ was conceived in the eighteenth century by the morbid and sick whose works of art were enhanced by the intake of drugs such as opium, hashish and absinthe (Porter 2002). The argument here suggests on one hand that inner turmoil is required for creativity to be injected in art production and on the other hand, persistence of inner turmoil signifies the absence of reason and the presence of madness.

Historical contextualisation of visual images of mental illness suggest that representations of mental illness are repeated images and stereotypic ideas in artworks made in the past and in contemporary culture (Gilman 1988; Eisenhauer 2008; Cross 2010). Art has become an important part of how

madness is understood in the past and in the present (Cross 2010). For Gilman (1988, p.18), art is a:

“... mental representation of some inner world... They are expressions of myths about the world, the ideas that we project onto it and that shape our understanding of the realities that we experience”.

Different expressions in art have suggested various philosophic thought about why certain images are representative of madness. An example is in the image of melancholic woman (*Melancholia I*, 1514 Albrecht Dürer, by in Gilman, 1988). Representations in the images of the *Melancholia I* or the *Cutting of the Stones of Folly* (Jan Sanders van Hemessen 1530 in Gilman 1988, p.21) are myths that foreground conceptions of mental illness in the fifteenth century. Gilman (1988) argued that art projected the female as the icon of melancholia, such that description of mental illness in reality or fictional materials often related passiveness to women. Art functioned to create images needed for the differentiation of the sane from the insane. The drive to establish an ‘other’ led to the production of art work in the eighteenth century, where images of madness in art suggested confinement of the mentally ill in state-run asylums that looked and functioned like prisons (Foucault 1965; Gilman 1988).

Thereafter, images of madness began to suggest typologies in external appearances that should be regarded as signs of mental illness. Physiognomy began in the eighteenth century and existed till the nineteenth century where illustrations of madness introduced humane means of treating madness in medical works (Gilman 1988). Growth in the production of images about madness started in 1850 when psychiatric illustrations were said to be enhanced by the use of camera photography. Sigmund Freud negated the notion that the external appearance of a person provides a better premise for judging the mental state of such persons. Freud's argument was that listening to a person, i.e. psychoanalysis was a better ground for interpreting than just seeing (*Ibid*). This led Gilman to argue that, though psychoanalysis is the genesis of improved clinical psychiatry, seeing as a tool for interpreting mental illness is still as crucial as listening even in contemporary times.

However, photographic representation of the mad began to assume the status of art in the nineteenth century (Gilman 1988). Images of madness in art enabled the identification of people as mad and in need of separation from those that are not. In other words, the strength of the visual stereotype is in its immediacy (Gilman 1988; Cross 2010). Representation of

madness in art led to the creation of images that sought to prove that certain facial or physical appearances are signs needed for instantaneous identification of the sane from the insane (Cross 2010). These images became the basis for making decisions on who should or should not be condemned to asylums. For example, images of Black immigrants produced by Britain's leading political and media powers led to massive repatriation and confinement of many Africans in the 1950s (Heaton 2013c). Publicised images of black immigrants presented colonial subjects as incapable of assimilating into British culture, quarrelsome, violent, suspicious, unsanitary, promiscuous, possessed criminal tendencies and in need of discipline (*Ibid*).

Images in art grew in form and size since the advent of photography, which also contributed to the growth of still and motion photography. As stated by Taminiaux (2009), the role of photography has led to the growth of the media. Visuals are an important component of journalism, advertising, and broadcast production: these forms of media have evolved through the integration of photography as a form of art, commerce and technique. Meanwhile, art, as an important source of expressing concepts and ideas about social issues

reflects constructions of social reality from the point of view of the art creator (Levi – Strauss 1981; Gamson *et al.* 1992).

Art as a communication medium has contributed to the preservation of images of madness from the past to the present (Gilman 1988). What is known of madness or insanity today is taken from incidences or happenings of the past that were preserved for us and narrativized through art, poems, folklore and many other oral or visual historical communication forms. Images in art are driven by the need for visual representation and identification of something. Art may also constitute an important way the mentally ill express strong emotions and feelings (Caughney 2011). Art has also being adopted as a means of reiterating images considered crucial to the description of madness across generations, cultures and beliefs (Eisenhauer 2008). As explained above, the gradual development of photography from art historically has engrained certain understanding of madness in various social settings. An example can be found in the growing notion that being a genius has a relationship with madness (Porter 2002; Lavis 2005).

Artworks are a media form that exist in many societies, but photography, either still or motion, appear as a more potent bearer of meaning in the representation of images of madness (Rose 1998). The increase in reproduction of specific images in order to elicit particular interpretations has popularised specific perceptions of mental illness. Images of the physically unkempt, delusional, incoherent in speech or unusually secluded are recurring referents for madness (Aina 2004; Cross, 2010; Atilola and Olayiwola 2011a; Heaton 2013c). In other words, the proposition that the media function as a major source of identifying and describing mental illness may influence a consistent and persistent way of conceptualising mental health issues. The recurring attribution of mental illness to danger and violence (Wahl 1992; Philo *et al.* 1996; Rose 1998; Knifton and Quinn 2008) are very good examples of how art as a media form function to communicate specific images of mental illness.

The interpretation of expressions in works of art and photography require the ability to comprehend historical and cultural biases associated with such representations. That is, if images of mental illness express the notion that madness can occur in individuals perceived as possessing high intelligence, associating genius with madness may become a

culturally generated perception of mental illness. Images in still art and cinematic products are similar on the basis that the images they foreground are mental representations of objects in the world (Cohn 2013). Meanings evoked in images of art and cinematic products fulfil the essence of a system of signification. Images produced through photography suggest a multiplicity of point of view (Baudry 1975). Images in art or cinematic products under go different negotiation processes (Henderson 1996) in order to ensure that message consumption is accompanied by knowledge effect; actualisation of the interest of the negotiation or work process; and acceptance or denunciation of projected ideology (Baudry 1975).

The conceptualisation of art as a vehicle for transmitting or communicating salient social issues is available within the Nigerian context. Art in this study is operationalised as a media form that expresses thoughts, ideas, feelings, and perception from the stand point of the art creator. Resources to advance argument on how specific use of art inform ways mental illness was known in the past, and for adequate comparison with works of art in the present are not available in the Nigerian context. Although, evidence to show that a relationship between madness, genius and art exist in Nigeria

is not available, creativity and high level of intelligence as unscientifically proven causative explanations for madness are perceptions of mental illness that exist in the various cultural enclaves within the country.

However, Nigeria was once a British colony and as a result of this, psychiatry emerged from the time of the colonials (Heaton 2013a). During the colonial rule, the British colonialist separated the 'insane' from the society through confinement, a similar practice with widely explained precept of psychiatry in European nations (Foucault 1965; Gilman 1988; Porter 2002; Heaton 2013a). Alternatively, African history suggest that the development of psychiatric medicine and its social control mechanisms were inversions of European and American cultural beliefs and values about mental illness (Heaton 2013b). It is worthy to note that majority of indigenous African population were regarded as the 'other' by the European colonialists who perceived the culturally and racially different as inferior to the European nationality (*Ibid*). This formed the basis for why British media advertised for immigrant Africans to be repatriated from Britain in the 1950s (Heaton 2013c). However, the emerging Third World did not agree with Western historical and cultural framework for analysing madness. Consequently,

Nigerian psychiatrists sought ways to redefine what post-colonial psychiatry should look like. An attempt at this was the planning and executing of the First Pan-African Psychiatric Conference in Nigeria by the first western trained psychiatrist, Adeoye T. Lambo in 1961, just a year after Nigeria became a sovereign state (Heaton 2013b).

From the point of view of ethno psychiatrists, Western psychiatry defined madness in ways that enhanced the power of the colonialist. Persons known to constitute a threat to the existence of the colonialist were subjected to 'psychiatric confinement and treatment' (Keller 2001). According to Keller (2001), Foucault's interrogation of psychiatric professionalization, evident in the coercive power psychiatry wielded in the twentieth century, have led ethno psychiatrists to engage in studies aimed at offsetting discourses on the dominance of western psychiatry. An example can be found in the way apparent alliance between colonial authority and western psychiatry encouraged Asians and Africans to return to traditional practices (Keller 2001) in a revolutionary attempt to decolonise western psychiatric practices.

4.7 REPRESENTATION IN MEDIA DISCOURSE

Analysing representations of social issues, particularly from the media perspective, is important because of the notion that media messages can potentially influence attitudes or beliefs (McQuail 2013). A better grasp of the concept has been operationalised by Birch (2002) who argues that representation is a process of producing meanings through the deployment of signs and language as a signifying system. Signs and symbols have conventional meanings that are arbitrarily understood from the way social groups interact and transmit information between inter and intra groups. Social relations and interactions that occur through language form the basis for social perception of social events as reflectors of social reality. According to Sibley, Liu and Kirkwood (2006), social representations reflect elaborated ways of thinking and acting in social groups. The ability to identify media texts as representations of meaningful social issues is enhanced through the process Sibley et al. (2006) refer to as anchoring.

“The degree to which attitudes toward a given social issue form strong and coherent evaluative associations with more general concepts and values related to that issue should therefore be indicative of the degree to which anchoring of that issue has taken place.” (Sibley *et al.* 2006, p.4)

However, it has been argued that social representations of issues may not influence a change in attitude or behaviour if that issue is heavily anchored in principles generally accepted by the society as a whole. And it is within this context that framing in the media is understood to preclude the salience of social issues that are anchored heavily or not in various social settings. For example, the media representation of media in this study has been hypothesised as framing themes of mental health in certain ways that suggest the popularity of traditional or spiritual mental health care over the science based mental health options. With reports from researches (Gureje *et al.* 2005; Adewuya and Makanjuola 2008; Armiyau 2015) showing that beliefs in supernatural causes in mental illness are heavily anchored in Nigerian society, representations of mental health in movies particularly, have shown that supernatural belief in explanations of causes and treatments of mental illness are high in the Nigerian cinema (Aina 2004; Atilola and Olayiwola 2011a; 2011b). This is because the media are thought to assume considerable responsibility for shaping public consciousness or for legitimizing certain values (Price 2007). Thus, from the argument made by Sibley *et al.* (2006), media framings of social issues may influence changes only in specific issues that are individualistic. And these changes can occur in the

absence of salient explanation of social issues that dominant social group provide.

From another angle, representations in the media may be perceived as reflection of issues that are heavily anchored in social representations, thus the notion that media contents are constructions of social reality. Price (2007) argues that texts or images that appeal to common knowledge and shared attitudes can be found in global action and the beliefs of a social group. Similar interpretations of texts are evoked when images are used to create specific meanings that producers expect to reflect meanings that are socially available in the meaning making structures of a social group. Thus, media representations of social issues are not entirely different to what exist in real social settings. Therefore, texts and images will have no significant meaning to decoders of media text if the images do not relate to the lived experiences of media texts receivers.

Although, debates on representation as a means of producing bias, manipulative and ideological messages (Fairclough 1995) offer long standing arguments against media texts as constructions of social reality. Fairclough presents the idea

that representation in media texts can be said to function ideologically in so far as they contribute to reproducing social relations of domination and exploitation. In other words, it is possible to talk about representations either in media or social context, when a knowledge base is sustained through production and reproduction of signs and symbols continually created and recreated to enhance social relations and understanding. Fairclough was attuned to the belief that the 'wider social impact of the media is not just to do with how they selectively represent the world, though that is a virtually important issue; it is also to do with what sort of social identities' (*Ibid*, p.17), versions of self; and cultural values are projected. Moreover, social identities, versions of self and cultural values exist in social representations of social groups.

Furthermore, 'social representations are societally elaborated and socially shared bodies of knowledge' (Sibley *et al.* 2006, p.10). In other words, texts produced by a representative of a specific social group that has its own version of social reality will likely frame issues in ways that ensure core knowledge systems are maintained while changes are allowed to take place on the periphery (*Ibid*). It is within this context that Hall

(1989) argues that we all write and speak from a particular place, time, history, and culture that is specific.

Representations of mental health issues across societies and in the media share similarities and differences. In relation to social representation of mental health issues, many perceptions and attitudes about mental health have deep cultural and religious roots (Knapp *et al.* 2006). Media portrayals of mental health issues often reflect beliefs that exist in social representations of mental illness. Thus, explanation on what is constituted by mental illness may be found in the 'public sphere of mediated images, representations and meanings of madness' (Cross 2010, p.2). However, Rose (1998) argues that social representations of mental illness do not necessarily make madness a familiar social issue. The crux of Rose's argument centred round the notion that social representations of madness do not conform to the view that social representations function to make the unfamiliar more familiar.

In summary, across different cultures, media representations of mental health are categorised as positive or negative, a categorisation that is often drawn from the underlying

influence of the most important social representations of mental health. Results from studies (Aina 2004; Atilola and Olayiwola 2011a; 2011b) have shown that movies from Nigeria are more likely to portray mental health issues from spiritual and religious perspective, a view many researchers, particularly advocates of psychiatry, have referred to as unrealistic (Gureje *et al.* 2005; Atilola and Olayiwola 2011a). Furthermore, Africans embrace mythology in explaining social representations of mental health issues in ways that run contrary to the foundational essence of psychiatry, which portend that magic has no relations with mental health (Islam and Campbell 2014).

The import of the reference made to myth here is in the assumption that mythic representations of mental illness in African setting may be responsible for the socially sustained reference to alternative beliefs for providing explanation for life incidences. According to Lévi – Strauss (1974), the sustenance of myth is dependent on oral transmission, collective tradition, lesser resistance to social attrition and the need to correspond to share needs. Levi – Strauss (1974) explains that myth may not be helpful in giving clear evidenced explanations on the order of the world; the nature of reality; or the origin and destiny of mankind, but may

enhance our understanding of the origin of societies; and provide clarification on reasons why certain beliefs, customs and institutions exist. In the absence of scientific explanations in science oriented social settings, myths form a major strong hold for making sense of what would have hitherto remained mysterious. For example, the legend of madness in African myth strongly reference alternative beliefs (Heaton 2013a), and these mythic ideas have remained in many generations through oral and cultural preservation. In this vein, mythic ideas are either retrospective or prospective in explanations or interpretations of present day happenings (Lévi-Strauss 1974). Retrospective deployment of myth involves explanation of social happenings from an 'attenuated mythical representation from the past, while prospective deployment of myth embraces the past in dealing with a future' that is still in the process of taking shape (*Ibid*, p.281).

CHAPTER FIVE

PERCEPTIONS OF STIGMA

5.0 STIGMA IN MENTAL HEALTH

Stigma refers to ‘bodily signs designed to expose something unusual and bad about the moral status of the signifier’ (Goffman 1963, p.11). Stigma encapsulates marking out the different, the deviant and the dangerous (Porter 2002). For stigma to exist, the society must establish categories of members that are normal, natural and ordinary (Goffman 1963; Davis 2006). These categories enable members of social groups to make judgement on socially constructed personal and social traits of an individual. Goffman referred to this practice of categorisation as social identity. Also, stigma is situated in the value judgement of the dominant group (Coleman 2006, p. 141). In other words, social identity, power relations and constructions of normalcy are central to conceptualising stigma (Goffman 1963; Davis 2006).

Stigma exists in the creation of spoiled identity: the act of making individual or group judgement by singling out people as different, inferior and responsible for the stigmatic situation (Porter 2002). Stigma of a social member thrives on

social identity that is based on physical, character and tribal defects (Goffman 1963). Persons suffering from mental illness fall into the character defect category of stigma, and on this account have to deal with a lot of issues. Some of these issues include living and suffering from the symptoms of mental illness (Rüsch, Angermeyer and Corrigan 2005); dealing with stereotypes associated with been described as an 'other' (Gilman 1988; Porter 2002) by culturally articulated images of mental illness (Eisenhauer 2008); and stigma - a resultant effect that consequently lead to different levels of social distance (Corrigan and Shapiro 2010).

Stigma is an important mental health related issue. Stigmatisation of mental illness exists everywhere, although the form and nature of it differ across cultures (Gureje *et al.* 2005; Abdullah and Brown 2011). Mental health stigma in particular is an attitudinal barrier, which has been demonstrated to influence basic human needs such as self-perception (self-stigma), employment, housing, interpersonal relationships, physical and mental health seeking behaviour (Coleman 2006; Maier *et al.* 2008; Sickel *et al.* 2014). According to Corrigan and Watson (2002), stigma can be categorized into self-stigma and public stigma. Self-stigma is described as the internalized consequence of stigma on an

individual due to endorsement of stigma by the society. In other words, self-stigma accounts for the deleterious effects of prejudice on individual's perception of him or herself after episodes of mental disorder (Corrigan and Watson 2002, p.18). Also, self-stigma may 'mediate attitudes towards seeking help for mental disorders when needed for self' (Sickel *et al.* 2014, p.207).

Public stigma is best described as the reaction general population show towards people with mental illness (Corrigan and Watson 2002, p.16). Socially manifested consequences of public stigma are evident in actions that result in refusing people with mental illness their rightful opportunities in relation to work and other life goals (Corrigan and Shapiro 2010). Self-stigma and public stigma follow a progressive process that starts with stereotype, prejudice and discrimination as main components of mental health stigma (Corrigan and Watson 2002). Stereotypic, prejudicial and discriminatory indicators of mental illness share a symbiotic relationship: the existence of one depends on the sustenance of the other. For example, stereotype is a negative belief about a group or self that leads to prejudice: negative emotional reaction as a result of agreement to the negative belief about a selected group. Prejudice in turn leads to discrimination, a

behavioural response to prejudice (Corrigan and Watson 2002). If for example, the perceived causes and manifestations of mental illness are attributed to moral decadence in the mentally ill, stereotypic perceptions of the mentally ill will be attuned to the perceived cause. To illustrate further, Weiner (1995) in Corrigan and Shapiro (2010, p.916) upheld a model of causal attribution that suggests that attributing personal responsibility for a negative event leads to anger and diminished helping behaviour.

As intricate parts of stigma, stereotype, prejudice and discrimination are important elements of mental health stigma. Stereotype has been described as representations that subject people to a set of exaggerated and negative character traits (Barker 2004). Different social formations such as places of treating mental illness; ways of treating mental illness; carers of the mentally ill; or manifestation of mental illness in the disordered enhance emergence and spread of mental health related stereotype. A practical example can be found in how the Neuro Psychiatric Hospital, Yaba in Nigeria is usually referred to as a centre for the 'mad' or '*were*' (Yoruba translation of mad - used derogatorily and descriptively to refer to the mentally ill). Sometimes, names of

mental health institutions such as 'Yaba' and 'Aro' (Neuro Psychiatric Hospital in Abeokuta, Nigeria) are used as ways of referring to someone as 'crazy' (see the argument above). By implication, mental health institution users become stigmatized. However, social indicators highlighted above are manifestations of public stigma that may affect decisions made to seek help for mental illness or disclose mental health status (Angermeyer *et al.* 2005).

Also, discrimination towards the mentally ill are referred to as behavioural reactions that follow prejudice. In this context, discrimination may appear in the form of 'withholding help, avoidance, coercive treatment and segregated institutions' (Corrigan and Watson 2002, p.17). According to Rüsch, Angermeyer and Corrigan (2005), social, economic and political powers play fundamental roles in the completion of stereotype, prejudice and discrimination as a circle. It will be difficult for a lay person to take decisions that would have discriminatory consequence on sufferers of mental illness if such person does not possess the power to influence social views and actions (Barker 2004). Power relations reside in social context. For example, Thomas Szasz (1974; 1987) and Michel Foucault (1965) have argued that madness in its disease form is socially manufactured because the dominant

group construct normalcy; and provide explanation on otherness, differences and abnormality that make up the norms, values and belief of a given society. If for example, the minority group, which in this instance are the mentally ill, were to possess the social power to construct normality, the sane will become the stigmatised group. Also, stereotype and prejudice as cognitive and emotional aspects of relating to mental illness may not necessarily lead to discrimination (behavioural) in the absence of a power influence that causes stigmatized group to be treated as the 'other' (Foucault 1965; Rüsç *et al.* 2005).

Stereotypes are considered social because they represent collectively agreed upon notions about a group of persons, while prejudice is simply the cognitive and affective response to the negative beliefs (Corrigan and Watson 2002). Stereotype in mental health exist in the general perception of mental illness among a group of people. There are differences in cultural manifestations of self-stigma and public stigma. In Western countries for example, perception of the mentally ill as dangerous is a popular stereotype of mental illness (Philo *et al.* 1996; Jorm 2000). Themes such as homicidal maniacs and childlike perception of the mentally ill are some

manifestations of stereotypes that exist among laypersons (Corrigan and Watson 2002).

Illustratively, if danger is attributed to a large number of mental disorders such as schizophrenia, depression and drug abuse through a series of social learning structures, perceptions of the mentally ill as unpredictable or dangerous will permeate as basic knowledge of mental illness. The belief that a person with mental illness is dangerous may result in feelings of fear towards the mentally ill (Porter 2002), which in turn may lead to avoidance (Corrigan and Shapiro 2010) of the mentally ill. Also, perception of the mentally ill is likely to differ from prejudice that occurs when causal blame is not apportioned to the mentally ill, especially when mental illness is understood from the view that a schizophrenic, for example, is different not on account of signs of disease, but because a schizophrenic deals with 'a rent in his relation with his world; and a disruption of his relation with himself' (Laing 1960, p.17). In other words, perceived causes and understanding of mental disorders pre-sets the form of stigma a social group will adopt towards mental illness.

5.1 SOCIAL DISTANCE AS A FORM OF STIGMA

Social distance is a 'multi-faceted concept that is influenced by socio economic and cultural factors' (Lauber *et al.* 2004, p.265). Social distance is a proxy measure of stigma which is influenced by factors such as perceived danger and unpredictability of the mentally ill (Marie and Miles 2008). For example, the level of social distance towards the mentally disordered have been observed to have a relationship with perceived danger in individuals suffering from schizophrenia, depression, alcohol abuse and substance dependence (Marie and Miles 2008). Reports suggest that the public are likely to have a stronger negative view about schizophrenia than other mental disorders (*Ibid*). These negative reactions are attributable to the notion that schizophrenics are 'unpredictable'. The contribution of the media in the spread of 'danger' as a theme of mental illness (Thornton and Wahl 1996; Philo *et al.* 1996; Rose 1998), and schizophrenia particularly has been reported (Knifton and Quinn 2008). In a scientific review, Jorm and Oh (2009) reveal that exposure to negative event in the media, such as violent crimes committed by people with mental disorders, can increase social distance from the mentally ill.

Also, popular representations of mental illness and drug addiction in news or entertainment media have been reported to influence public attitudes towards these conditions (Thornton and Wahl 1996; McGinty *et al.* 2015). For example, in a study by Angermeyer *et al.* cited in Jorm and Oh (2009, p.186), a marked increase in social distance from schizophrenics was reported in Germany as occurring due to watching a lot of television; and reading tabloid/regional newspapers. The idea is that media in its emotive style (*Ibid*) of reporting psychosis and violence circulate messages that suggest views that acts of violence are committed by schizophrenics (Marie and Miles 2008). The consequence of such representations are reflected when stories about mentally ill killers encourage fear of and harsher attitudes towards those with mental illness (Thornton and Wahl 1996).

Portrayals of persons with untreated symptomatic mental illness in the media function as a conduit for constructing and reconstructing normality. With many depictions of schizophrenics in the media, many conceptions of madness may be linked to images that the media suggest, thereby institutionalising the media as a powerful element in social constructions of normalcy or abnormality, sanity or insanity. According to Coleman's (2006) model on stigma in disability

studies, stigma functions through primary affective, behavioural and cognitive components in social contexts. Images of mental illness in the media perform these three functions. Affective functions of the media are reflected in associations made to fear in relation to mental illness. Examples are themes of violence and danger that images of mental illness constantly draw upon in media representations. The behavioural component of the media is reflected in its power to control social views on mental illness. Consistent portrayals of mental illness from the past have enhanced a continued way of seeing the mentally ill. The media have been able to control this consistent way of seeing or perceiving madness in its persistent attributions of violence and danger to madness. Lastly, stereotyping, which constitutes the cognitive component of stigma as proposed by Coleman (2006), is found in the specific choices made in the projection of mental illness. The argument here is that the media control social perceptions of mental illness through stereotypic association of mental illness to danger or violence.

To buttress the argument provided above, social distance towards the mentally ill may improve if portrayals in the media are of successfully treated mental disorders (Thornton and Wahl 1996; McGinty *et al.* 2015). In this instance,

conceptualising the media as an agent of social control gives off the view that media images that suggest that the mentally ill is an 'other' who has equal right as the 'normal' may eradicate concepts such as social stigma or social distance. Although more studies may have investigated negative representations of mental illness in the media (Wahl 1992; Philo *et al.* 1996; Aina 2004; Knifton and Quinn 2008; Atilola and Olayiwola 2011; Owen 2012; Cross 2014), some studies have shown that the media can function as a vehicle for representing mental health issues in ways that can change negative perceptions to positive ones (Birch 2002; Demyan 2009).

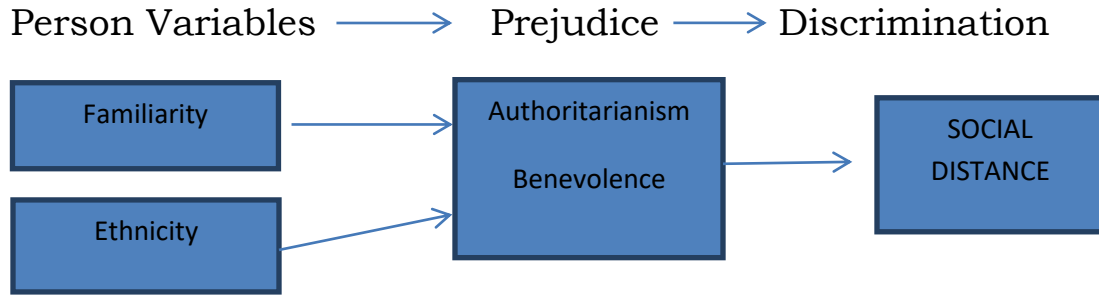
5.2 SOCIAL DISTANCE AND ITS FORMS

Emotional reaction to views that the mentally ill are 'unpredictable', 'frightening', 'threatening' or 'disgusting' (Link *et al.* 1999; Porter 2002; Lauber *et al.* 2004; Marie and Miles 2008) are reflected in the level of social distance people will have towards the mentally ill. The emotional reaction is what has been conceptualized as expressed emotions (EE). Expressed emotion is a construct that encompasses several key aspects of close personal relationships people are willing to have with the mentally ill (Barrowclough *et al.* 2005). For

example, in a cross sectional study of two separate samples of carers of mentally ill persons with single diagnosis (schizophrenia) and dual diagnosis (schizophrenia and drug or alcohol misuse), Barrowclough *et al.* showed that expressed emotions was largely influenced by a marked difference when causal ascriptions are made to deficit behaviour (*Ibid*, p.884). In other words, high expressed emotions that appear in the form of hostile and critical disposition towards the disordered by carers occurred more in dual diagnosis patients. In line with this, an explanation Barrowclough *et al.* (*Ibid*) gave is that patients with dual diagnosis: mentally disordered from two psychiatric diagnosable illnesses, are perceived as able to control their problematic behaviour and symptoms, perhaps by avoiding actions that led to the disorder in the first place. For instance, a mentally disordered suffering from substance abuse may experience hostility from carers because it is believed that the sufferer's decision to abuse drugs has led to mental disorder. Meanwhile, low expressed emotions in care givers have been attributed to emotional involvement of carers (*Ibid*, p.885). The emotional involvement described here can also be understood from the level of familiarity a person has with mental illness (Corrigan *et al.* 2001).

Familiarity in mental health may be understood in the light of: a person who sees portrayal of mental illness as his understanding of mental illness; a person who has a friend or co-worker who has mental illness; a person who has a family member who has mental illness; and a person who has mental illness himself or herself (Corrigan *et al.* 2001, p.220). In a study carried out to propose and confirm a model to explain the relationship between social distance and prejudicial attitudes as factors that affect social distance, Corrigan *et al.* (2001) argue that prejudicial attitudes influence social distance. Examples of such prejudicial attitudes are: *authoritarianism*, which includes belief that persons with mental illness are inferior to normal persons; and *benevolence*, which is some sort of kindness towards the mentally ill like that of parents to their kids. The model further explains that certain variables in a social setting - such as familiarity with the mentally ill or the ethnic group the mentally ill or 'carer' belong to - may affect the emotional response and the level of social distance laypersons are willing to have towards people with mental disorders.

Table: 1



(Path model by Corrigan *et al.* 2001)

In addition, low expressed emotions (EE) may occur in persons with low level of familiarity with mental illness (Corrigan *et al.* 2001). However, Jorm and Oh (2009) argue that claims made about stigma in mental health - such as views that personal contact reduces social distance - are not entirely correct. They argue that contact with persons suffering from mental illness is not always positive. Consequently, stigma may occur in specific types of interaction with madness, which may increase or reduce the social distance people are willing to have towards the mentally ill.

5.3 CULTURAL INFLUENCE ON STIGMA

Different from the adoption of familiarity (Corrigan *et al.* 2001) to explain reasons for certain cognitive, emotional and

behavioural reactions towards mental illness, ethnicity is also identified as an important factor that impacts on social perceptions of mental illness. Goffman (1963) called this a form of tribal stigma and is associated with racial, ethnic, religious or national identity of individuals or groups. Also, some socio-demographic characteristics such as sex, religion and age are factors that shape people's assessment and behavioural predisposition, either positive or negative, to mental illness (Martin *et al.* 2007). In sum, culture is inextricably bound to stigma because the behaviour and belief people hold; and the social standards they abide by are based on the norms in that social context (Colemnan 2006; Abdullahi and Brown 2011). Furthermore, cultural influence of stigma will be further examined by looking at ways stigma is manifested in different cultural settings; and the consequence of stigma on seeking help from psychiatry.

5.3.1 Cultural Manifestations of Stigma

Differences occur in cultural manifestations and experiences of self-stigma and public stigma. In western countries, 'danger', especially attribution of 'homicidal maniacs' to people with mental illness (Corrigan and Watson 2002), is common. In Islamic societies for example, stigmatization of

psychiatric illness is attached primarily to the more chronic forms of mental illness that fail to respond to traditional treatments (Corrigan and Watson 2002). Again, in the Italian speaking part of Switzerland, greater level of social distance towards the mentally ill was observed when compared with results from Europe and North America (Lauber *et al.* 2004, p.24). In another cultural setting, greater social distance was desired from males than the females who suffer from mental disorders (Jorm and Oh 2009). In other words, societies may have similar manifestations of stigma towards mental illnesses; more paramount is the notion that stigma manifest in cultures at various degrees.

There are claims that stigmatization of mental illness may be less common among Africans (Fabrega 1991 in Gureje *et al.* 2005). However, Adewuya and Makanjuola (2005) have challenged the notion that stigma and negative attitudes towards the mentally ill are less severe in Africa than in other Western cultures. In the study by Adewuya and Makanjuola (*Ibid*), the levels of social distance that Nigerian University students have towards people suffering from mental illness were investigated. In their report, a large number of students had high social distance towards the mentally ill, which made them to observe that students who will ‘probably/definitely’

feel ashamed (10.9%) if people knew someone in their family had mental illness were fewer compared to those who will 'probably/definitely' not marry someone (79.0%) that has mental illness.

By way of illustration, the relationship between culture and popular understanding of mental disorders is foregrounded when seeing things and hearing imaginary voices are perceived normal in some cultures (Middle Eastern cultures), but considered a pathology in another (Western cultures). In western cultures, hearing or seeing things that are not visible to others is referred to as hallucination, while a person from African descent who values spiritualism might believe that the hearers and seers of things not visible are cursed, or in some context are spiritually powerful or strong (Abdullahi and Brown 2011, p.939). Thus, cultural interpretations of mental illness influence ways members of cultural groups perceive mental disorders (Wig 1999; Rashed 2013).

The different religious, racial, ethnic, socio-demographic groups individual members belong to affect what they come to know of causes, symptoms and possible treatments of mental disorders. An example is in Islamic society where

stigmatization is more towards certain mental illnesses that fail to respond to alternative treatments (Corrigan and Watson 2002). An example of such alternative treatments of mental illness in Islamic culture is ‘*ruqyah*’: a spiritual/religious ritual that involves the recital of certain prayers in the Islamic tenets, similar to what is regarded as exorcism in other cultures. Another example of cultural manifestation of stigma can be found in Western societies where ‘danger’ is more openly associated with the mentally ill (Rose 1998). Therefore, from variances that occur in social and cultural manifestations of mental illness in different societies, the level of violence attributed to mental illness in Western cultures are likely to vary from the level of violence that other cultures will attribute to mental illness.

5.3.2 *Stigma and Help Seeking*

There appear to be more similarities than differences in socio-demographic characteristics and beliefs of illness on one hand and attitudes held towards help sources and treatment modalities on another (Angermeyer *et al.* 2005, p. 863). From the argument made so far on social and media representation of mental illness, there exists a tendency for the public to rely more on alternative treatment methods in countries with less

developed science-based mental health care systems (Heaton 2013a). A preference for alternative treatment methods for mental illness may be linked to socially acquired interpretations of causes of mental illness.

Perceptions of mental illness are strongly associated with mental health stigma (Gureje *et al.* 2005). For example, stigma, particularly from proponents of psychiatry in Nigeria, may be associated with the adoption of alternative explanations of mental illness. Science based theorists are likely to constitute a major source of stigma for adherents of alternative beliefs in mental illness due to the strong negation psychiatry has towards such beliefs (Porter 2002). For instance, from reported manifestations of stigma, Gureje *et al.* (2005) argue that some Africans perceive drug abuse as reasons for the emergence of mental illness. In this instance, conception of cause is self-infliction, thus associated stigma and help seeking behaviour will be attuned to the conception of cause. In other instances where causes of mental illness are not associated with self-infliction, the level of stigma towards the mentally ill will differ from when causes of mental illness are suggestive of emanating from travails of childbirth or magical enchantment.

However, based on the assumption that media messages can act as teachers of values, ideologies, and beliefs, media messages provide images for interpreting the world whether or not the designers are conscious of this intent (Gamson *et al.* 1992; Clement *et al.* 2013). In the study by Clement *et al.* (2013), two key aspects of stigma: discrimination (treating people unfairly because of the group they belong to); and prejudice (negative attitudes and emotions towards certain groups) were focused on. Their review compared people who saw or heard a mass media intervention about mental health problems with people who had not seen or heard any intervention, in order to find out if the use of mass media interventions can reduce stigma. The result showed that mass media interventions may reduce prejudice. Subsequently, some have argued that mass media interventions that emphasize positive themes, with particular emphasis on contents that contradict widespread negative perceptions of mental illness may reduce prejudice towards specific mental illnesses (Demyan 2009). Further discussion on the function of the media in the spread or reduction of stigma is provided in the next section.

5.4 MENTAL HEALTH STIGMA IN THE MEDIA

In furtherance to arguments made so far, stigma has a relationship with views held about mental illness. It has been argued in preceding sections that causal attributions made to mental illness influence prejudicial and stereotypic attitude laypersons have towards the mentally ill. Also, studies have shown that stigma is fuelled by notions of causation that imply that affected people are in some way responsible for their illness (Gureje *et al.* 2005; Knifton and Quinn 2008). However, popular views of mental illness in art, medicine and popular culture (Eisenhauer 2008) structure cultural identification of the mentally ill within the context of widespread belief (Abdullahi and Brown 2011). Thus, unquestioned repetition of stereotypic images and negative representations of mental illness may provide a background for explaining stigma in the media (Eisenhauer 2008).

Mental illness may be described as one of the most stigmatised health conditions. An example can be found in ways employers refuse to give job offers to applicants who are believed to have a history of mental illness (Page and Day 1990). Arguments from studies suggest that stigma inhibits the lives of people that are experiencing mental health

conditions (Birch 2002; Clement *et al.* 2013). Stigma in the Nigerian context can be evaluated in the layman's disposition to elements of stereotype. For example, stigmatic themes of name calling and associating danger with the mentally ill were found in media representations of mental illness in this study. The notion that the media shape perceptions of persons with mental illness; persons who seek help; and mental health care givers, suggest a relationship between media representations and stigma (Maier *et al.* 2013). In other words, media portrayals may enhance stigmatic perceptions of mental illness by 'emphasizing bizarre symptoms and disproportionate depiction of psychotic forms of mental illness, as opposed to milder ones' (Bryd *et al.* 1980 in Wahl 1992, p.345).

For instance, studies carried out in the UK (Philo *et al.* 1996) and Scotland (Knifton and Quinn 2008) show that newspaper depictions of mental illness emphasize negative themes that contribute to stigma. Although, representation of mental illness in newspapers produced in Nigeria could not be ascertained, newspaper representations of health issues generally have been reported by Onyeizu and Binta (2014). In a study of newspaper coverage of health issues in Nigeria, *The Guardian* and *The Punch* newspapers specifically, it was

reported that health issues were poorly represented (Onyeizu and Binta 2014). In the report, straight news appeared as the most (32.9%) adopted channel for reporting news on all health related issues.

Deductively, general health issues may be poorly reported in the Nigerian print media (Onyeizu and Binta 2014), but for a better grasp of print media representation of mental health issues in Nigeria, further research will be required. However, the absence of studies that have explored print media representation of mental health issues does not opine that newsprint in Nigeria do not report on mental health issues. It is the level, style, and form of these representations that may not be ascertained. Thus, with the report that general health issues are poorly reported in newsprints in Nigeria, it may be safe to argue that reports on mental health issues in Nigeria are likely to be poor if mental health issues were included in the report of Onyiezu and Binta (2014).

Furthermore, positive or negative social perceptions, attitudes or behaviour people have towards mental health issues may be associated with media representations of mental illness. In reference to reports that suggest media messages convey

negative views on mental health issues, Jorm and Oh (2009) argue that exposure to negative events in the media, such as violent crimes committed by people with mental disorders, increased social distance towards the mentally ill. Also, Marie and Miles (2008, p.131) argue that media representations that relate psychosis to violence perpetuate meanings that suggest that disproportionate number of violent acts are committed by individuals with schizophrenia.

On another hand, media representations of mental health issues that are categorised as positive are found in portrayals of successful treatment of mental illness. Thus, mental health themes that fall under positive representation of mental health issues may constitute a powerful anti-stigmatic tool when they are made to counter negative themes in portrayals of persons with mental illness and addiction (McGinty *et al.* 2012).

In addition, a number of anti-stigma studies have investigated media role in informing; shaping public attitudes; and selectively triggering pre-existing bias about mental illness (Philo *et al.* 1996; Wahl 2003; Knifton and Quinn 2008). For instance, these studies have all confirmed

views that negative depictions of mental illness outweigh positive representations in the media. However, anti-stigma studies that blame the media for negative representations of mental illness have been criticised. According to Harper (2005), anti-stigma studies (Wahl 1995; Philo *et al.* 1996) are a little over-generalised and limited in the description of what constitutes violence in anti-stigma discourses. By arguing views proposed in the Glasgow Media Group's study, *Media and Mental Distress* (Philo *et al.* 1996) that focused on the UK; and Wahl's (1995) *Media Madness* that focused mainly on media representation of mental distress in the USA, Harper (2005) has argued that mental health representation of violence in the media is not necessarily higher than what is obtainable in the real world. Harper (2005) argues that real life reports suggest a correlation between schizophrenia and violence. In anti-stigma studies, association made to violence and schizophrenia in the media has constantly being refuted and referred to as stigmatising. To reduce these tendencies, Harper (2005) suggests that the incidences of violence by the mentally ill in media messages needs a parallel comparison or control in the study of incidences of violence in real life and in incidences of violence reported in the media by people who are not mentally ill.

The crux of Harper's (2005) argument is that audience's attribution of truthfulness to information in news media may not exactly be correct. Harper explains that truthfulness ascribed to news media messages are different from the verisimilitude ascribed to messages from popular fictions. He argues that the exigencies of genre and narrative forms affect mental health representation in news and fictional media, even in situations where the plot in the movies are adaptations of stories reported in the news media. By citing the difference found in the movie called *Spider* (McGrath 1992; Cronenberg dir., 2002 in Harper 2005), an adaptation of a novel by Patrick McGrath's about a schizophrenic, Harper argues that the book and film offer two different perspectives on mental illness. The different perspective that occurred in the movie adaptation of a novel with similar narratives was attributed to one person narrative in books that can only be visualised in movies. Central to this argument is that need for messages that evoke specific meanings in audiences affect ways narratives present images of mental illness. In summary, Harper suggests that future studies that investigate media images of mental illness should put formal and generic differences that exist between texts; the social function media chooses to fulfil; and socio-cultural formation of intended

audiences of media messages into consideration (Harper 2005).

In the Nigerian context, Atilola and Olayiwola (2011a) observed that, other than sporadic appearances of some psychiatrists on television, a well-structured institution based strategy for exploring the electronic media as a tool for promoting mental health literacy in Nigeria may not exist. This position surfaced in a study that analysed the content of twenty-one movies produced in years 2007–2009 in Nigeria with themes of mental illness. From analysis of the study carried out by Atilola and Olayiwola (*Ibid*), preternatural/diabolical causes of mental illness and unorthodox treatment modalities emerged as the most prominent themes of mental illness in the movies. The report showed that a large number of people feel that scenes from Nigerian home videos about causes and treatment of mental illness agree with everyday reality; and reflect their understanding of causes and treatments of madness. The majority of those who held these views were reported to be women who are less schooled. Thus, in western and Nigerian context, Harper's argument for a need to compare real life perception of mental illness with media representations may be justified. However, there is also that important aspect in

social structures where media function to control social views on issues. From this perspective, media constructions of mental illness may become confused as real life views if social members get most of their information on mental illness from the media.

On the other hand, the study by Atilola and Olayiwola (2011a) may have suggested the importance of knowledge transmission from one generation to another; and the underlying effect of misinformed interpretations of causes and treatments of mental illness in any given community. Although, the media may be a tool for transmitting knowledge, values laypersons pay to patriarchal or culturally explained phenomena in a society may outweigh those transmitted by other channels of social learning such as: print and broadcast media; and social interactions. Multiplicity of channels for value transmission may pose a challenge for producers of media content who become torn between producing socially acceptable perceptions or anti-stigmatic portrayals of mental health issues to a group of people who may find it difficult to shift from socially agreed perceptions of mental illness. An explanation for why social members who are producers prefer to adhere to popularly held views about mental illness can be attributed to the fear

of reprisal Elizabeth Noelle-Newmann theorised in 1974. Also, another reason why movies present mental illness the way they do may be due to commercial concerns that dictate important elements of media content, which in turn promote privatization of culture (Schiller 1989 cited in Gamson *et al.* 1992). In Schiller's argument, media constitute a central component of an organic process that enables corporate 'voices' to become generalized across an entire range of cultural expression. This view provides an explanation on factors that may be responsible for the popularity of certain frames of causes and treatments of mental illness in the media.

CHAPTER SIX:

CONTEXTUALISING MEDIA REPRESENTATIONS WITHIN

THEORETICAL FRAMEWORKS

In this chapter, media discourse will be contextualised in theories of media influence; social construction of reality; film/narrative theory; and ideological framings. The essence of bringing all these theories together is the specificity that each framework brings to the discourse of movie representations of mental health issues. Also, critical discourse analysis has been explored in this chapter to provide background information on the relevance of discourse analysis to this study. All the theories discussed in this chapter have influenced the process of interpreting and discussing data in this study. Thus, establishing a background relationship between these frameworks and movie representations of mental health issues have become more imperative.

6.0 MEDIA INFLUENCE

The media constitute an important public source of information that the level of media readership or viewership; and perceptions of influence found in matters relating to

mental illness attest to (Knifton and Quinn 2008; Hoffner *et al.* 2015; Quintero Johnson and Riles 2016). Although users of the media believe that they are invulnerable to media messages, social and media psychologists have argued strongly that media images influence our perceptions of reality without us realising it (Dill 2009). Debates on media influence theories are fuelled by views that audiences respond overtly or covertly to media adverts; are attracted, absorbed, and retained in attention getting media messages; consume media products at a high rate, all of which are made possible through an effective flow of information from the media to targeted groups, using systematic editing and interpreting (Happer and Philo 2013).

The level of media influence may also be observed in ways audiences rely on the media for information on issues they do not have knowledge or experience about. For example, this notion that the power of media messages tend to increase in the absence of direct experience and knowledge of an issue surfaced in a study of UK news coverage of attitude and beliefs about disability and disabled people (Happer and Philo 2013). According to Happer and Philo, violence in media representation of the mentally ill was largely refuted by individuals who work in the area of mental health. However,

people with direct experience of mental illness can argue that a minority of those with mental health issues are potentially violent because they talk about mental illness from a point of view that has not dominated social and media spaces.

In a number of studies that looked at factors that may impact choices people make about their mental health in Western nations (Vogel *et al.* 2008; Demyan 2009; Maeir *et al.* 2013), the media, in its dominating status (Dill 2009), feature more as the leading source of information on issues of mental health. The mass media have been observed to play a role in the promotion of beliefs and ideas that constitute attitude and behaviour people have towards mental health (Demyan 2009; Corrigan and Shapiro 2010; Anderson and Austin 2012; Birch 2012; Clement *et al.* 2013). For example, researchers have studied ways stigma - as enhanced by the media - influence people's intention and attitude towards seeking help (Maeir *et al.* 2013). In another study, exposure to certain media contents with particular themes around depression have been reported to affect decisions made to seek help from professionals (Vogel, Gentile and Kaplan 2008). Although, quite a number of researches have analysed themes of mental illness in contents of media messages, little exist of empirical study that show exactly how media

messages on mental illness verifiably influence the attitude and behaviour of audiences.

In recent times, studies on perceived media influence (Quintero Johnson and Riles 2016) have explored ways media prime stereotypic conceptions about mental illness that may subsequently influence the mechanisms of social stigma. Some other studies have deduced that exposure to television shows do impact on perceptions of psychological services (Vogel *et al.* 2008; Maier *et al.* 2013). In addition, Happer and Philo (2013) argue that power of media messages is heightened in situations where the audience had no prior knowledge or experience of a social issue.

In Maier *et al.* (2013), central questions concerning ways perceptions of three key figures; PSHs (people seeking help), PMIs (people with mental illness), and PCTs (people conducting therapy) in real life influence self-stigma was investigated. Perceived media roles in the shaping of perceptions of mental health issues through portrayals of psychiatric professionals in narratives were included in their study. The result from the study by Maier *et al.* (2013) shows that the more people viewed psychologists and people seeking

help negatively, the more stigmas the mentally ill will hold for themselves if they were to seek help. Furthermore, media portrayals of psychologists and people in therapy also affect perceptions of therapy and mental illness (*Ibid*). In other words, media affect perceptions of mental illness in almost all the major ways that mental illness can be conceived. Perceptions of mental illness do not thrive only on behavioural representations that bring about self or public stigma, but exist in representations of places of treating mental illness and mental health care professionals. Media representations have cut deep into many possible areas of mental illness and have thus projected itself as an important social structure for the construction of social perceptions of mental illness.

In another study, Vogel *et al.* (2008) looked at exposure to TV drama and comedy shows as predictors of attitudes related to help-seeking behaviour. They found that TV exposure was positively linked to stigma and negatively related to attitudes toward seeking therapy. In their study of the *Influence of Television in Seeking Therapy*, Vogel *et al.* (*Ibid*) used structural equation model to examine the relationship between exposures to television programs; perceptions of therapy; and intentions to seek therapy. The result of the

findings fully supported the notion that the relationship between television exposure and attitudes was fully mediated by stigma and anticipated benefits (*Ibid*, p.276), with results showing that frequent exposure to comedy and drama television significantly predicted viewer's attitude towards psychological services. This was explained against the backdrop of reasoned action theory and Gerbner's (1969) cultivation hypothesis, which elucidates that images presented on television can have a significant influence on constructions of reality; and a person's tendency to engage in certain behaviour (Vogel *et al.* 2008).

Furthermore, in a study by Aina (2004), the portrayal of psychiatry and the activities of supernatural forces in indigenous West African films were examined. In about 163 movies that were analysed, a relatively large number (n=25, 15.3%) contained scenes of psychiatric illness that frequently attributed causes of illnesses to supernatural or preternatural beliefs. In establishing the importance of the media as a major source of information about mental illness, Aina (2004) explained that some patient from personal experience attribute causes of mental illness to supernatural factors while quoting movies as their sources of information.

In summary, filmic texts are constructed for specific categories of audiences; and for specific reasons predetermined by key players in the production and dissemination of media contents (Henderson 1996; Mosco 1996). Cultural belief, knowledge, experience and participation are important components that inform perceptions and attitude people have towards mental health issues (Rashed 2013). In the absence of a concrete and fully experienced explanation on causes and treatments of mental illness, audiences are likely to adopt ideas that movie messages represent. However, mediated mental illness may be contested in situations where movie messages are at variance with popularly held views on mental illness; or if real life experiences do not support mediated views on mental health issues. However, if media contents constitute a major source of seeking information and knowledge about social issues, it may serve as a source of influence for the individual who perceives the media as such. Although, Hall (1982) in Gamson *et al.* (1992) argue that people are not “cultural dopes” who passively read texts just the way the producers intend. In their explanation, texts and images can incite multiple meanings in audiences, since some ‘texts may have a preferred meaning and point of view which the reader is invited to accept’ (*Ibid*, p.388). The reality remains that the

audience is still at liberty to accept or decline media messages, either by negotiating meanings from popular or dominant ideologies or by aligning with views that are oppositional to mediated messages. Various social factors influence the ability of the audience to make these decisions. But in situations where audiences are selective of the messages that they receive from the media, the influence of the media will expectedly reduce (McQuail 2013). That is not to say that media influence may not happen in such instances, what is worthy of note is that convincing messages on mental health issues from popular media may affect perceptions, attitude and behaviour that are held towards mental illness.

6.1 MEDIA MESSAGES AS SOCIAL CONSTRUCTION OF REALITY

From the preceding section on media influence, it has been argued that the media are influential in the formation and reinforcement of negative views on mental illness (Philo *et al.* 1996; Rose 1998; Aina 2004; Atilola and Olayiwola 2011a), and that popular films are especially more powerful in influencing attitude (Dill 2009; Owen 2012). Media influence has been discussed in the preceding chapters and the intent

in this section is not to repeat earlier arguments. However, in Africa, attitude to mental illness is reportedly consistent with intolerance people show towards sufferers of mental illness (Gureje *et al.* 2005). In this vein, if a substantial fraction of people get their health-related information from television (Vogel *et al.* 2008), the next quest will be to explore if contents in the media are projections of social constructions or if media messages function as constructors of social values, beliefs and practice. Here, arguments on media representation of mental illness will move away slightly from the notion of media influence to theorising ways media messages function as constructs of social reality.

Social constructionism, as Burr (2003) puts it, is an approach in social psychology or sociology (Berger and Luckmann 1966), that seeks to explain knowledge and social action from cultural or historical perspectives without necessarily arguing that one way of understanding social interaction represent the truth about the world. Social constructionism holds the view that there are numerous possible constructions of the world, and that each individual construction provides a version of reality to only the social group that these constructions represent. In this context, the debate on realism of social construction is fuelled because

social constructionism denies that knowledge is a direct perception of reality (Burr 2003). Knowledge here is seen more as something people do together, the creation and sustenance of social phenomena through social practices. The practice of social constructionism focuses on directing problems away from the *pathologised* to the social structure that *pathologises*.

Social constructionism is twofold: the micro aspect focuses on individuals as agent in control of the construction process; and the macro structure focuses on the view that 'constructions are the product of social forces, either structural or interactional' (Burr 2003, p.20). One major criticism of social constructionism is in the dichotomy of the micro and macro structures. Burr argues that this dichotomy has not adequately theorised the relationship between the individual and society. The problem with theorising the relationship between the individual and society is in establishing which agency, human or social, is influencing the other: is the individual influencing social constructions and interactions or is the social structure influencing the individual? According to Burr, if the macro structure is emphasized in social constructionism as an approach, the existence of human agency; the critical importance of

individual differences; and subjective experiences of life is threatened. And the problem with emphasizing human agency over social agency is with the notion that the individual cannot be said to be a sole construction of the society. Thus, Burr argues that social constructionism should focus on an embodiment of human and social agency in the explanation of social constructions. The individual cannot exist without the society, and the society is meaningless without the individual, thus social constructionism is better approached by avoiding the individual/social dualism (Berger and Luckman (1966).

Now, attempts made at contextualising media representation of mental health issues show that there exists doubt over views that the media construct social reality (Maier *et al.* 2013). The view that media present symbolic messages that reflect social reality is part of what is often contested. In some contexts, media in its own right has a powerful influence on the construction of views and attitudes in the real world without necessarily reflecting what is perceived to be real in the society. If the media truly influence attitudes and behaviour as argued earlier, this indicates that audiences are passive readers of media messages. The notion that readers of media messages are cultural dopes may have been debunked

with argument that readers do not exactly read messages or give meanings to messages exactly the way producers want it (Gamson *et al.* 1992). However, Entman (2007) argues that the dichotomy implied in a well-known axiom that the media provides people with ‘what to think’ and not ‘what to think about’ is flawed. Entman (2007) argues that the influence of the media on what people decide, favour or accept in media messages is not entirely different from the notion that the media can influence action by giving people what to think about; and ensuring that they think about an idea in certain ways.

On another hand, framing is crucial to contextualising media messages as constructs of social reality. According to Gamson *et al.* (1992), cultural level analysis show that the political world we live in is framed through pre-organised reports of events brought to us through media messages without necessarily implying that receivers of messages are passive processors of texts. However, active processors of media contents make media sphere a site of struggle for many who compete for the construction of their own version of social reality through framing (Gamson *et al.* 1992; Dill 2009). The position held by Gamson *et al.* (1992) is that texts sometimes have a preferred meaning the reader or audience

of a media message is invited to accept or reject based on preference for alternative readings. In other words, texts evoke multiple interpretations and meanings in audiences or readers, since there cannot be just one fixed way of interpreting signs and symbols in a context that is vulnerable to series of meanings.

Similarly, social constructionism upholds the view that there exists a potentially infinite number of alternative ways of presenting constructions of events (Burr 1998). For example, social interactions that make multiple perceptions of mental illness dominant will reflect social constructions that will relate mental illness to a number of possible interpretations. It is this multiplicity, diversity, fragmentation and localness that Burr (1998) referred to as the power of social constructionism. However, there is the problem of little guidance on which course of action is to be taken from the various options of social constructions. This lack of guidance has fuelled debates on realism and relativism in social constructionism. Burr (1998) argues in a debate on *Realism, relativism, social constructionism and discourse* that social constructionism questions the idea of the “objective fact” and at the same time characterizes the discipline and practice of

psychology as partial, value-ridden and driven by implicit vested interest (Burr 1998, p.14).

Relativist view questions the reason for abandoning the notion of a reality which bears some relation to our construction of social events. Relativity in the way knowledge of social issues challenge reality claims thrives on resisting having reality all pinned down and described as a 'once and for all' way of situating real life issues (Burr 1998). However, realism on the other hand cannot be said to be entirely different from relativism. Realism is reality behind social phenomena and has become the reason why some researchers adopt relativism to explain what truly is a representation of reality (*Ibid*). What is true about reality is based on what appears to us as true in the way truthful reality affects our lives.

The existence of a multiplicity of perspective in interpreting social events leads to a bewildering array of alternatives, which brings with it the question of how one is then expected to decide between alternative perspectives. In Burr's (1998) view, the justification for advocating one view or social life over another and the possibility of avoiding 'moral relativism',

informs some of the arguments that fuel relativism/realism debate in social constructionism. Also, Burr (*Ibid*) argues that social construction makes us conscious of the diversity and difference in humanity, but argues that if we insist on difference and diversity, we paralyze ourselves by denying the possibility of identifying collective interest.

Furthermore, social construction of reality as an approach encapsulates dissecting ways constructions of reality become relative and provide answers to why differences occur in the way knowledge interferes with what comes to be known as reality. Socially agreed upon knowledge that is drawn upon for interpreting social happenings affect how members of social groups interpret social issues. From the perspective of mental health, a society whose knowledge of madness is sourced from a particular point of view may find it difficult to activate alternative views as social reality. Illustratively, Africans are known historically to attribute magic or spiritualism to mental illness (Gureje *et al.* 2005; Fernando 2010). So, in rural areas where magical or spiritual views on mental illness are highly appreciated and access to some media (internet) is relatively low, a social rejection of psychiatry is a possible reality.

However, Collier (1998) provides further explanation on this by suggesting that reality can be best understood through concepts such as consciousness, experience, language and practice; and that language can only be learnt through reference to reality. In other words, reality is given to us through language, which is responsible for enhancing our predated experience with the real world (Burr 1998; Collier 1998). According to Berger and Luckmann (1966), knowledge in social construction of reality exist in the realisation that every individual is born into an objective social structure within which he encounters the significant others who take charge of his socialization. These significant others are imposed upon him. Definitions of life situation are posited for him as objective reality by the significant others. He is thus born into not only an objective social structure but also an objective social world. The significant others who mediate this world to him modify it in the course of mediating it. They select aspects of it in accordance with their own location in the social structure, and also by virtue of their individual, biographically rooted idiosyncrasies. The social world is 'filtered' to the individual through this double selectivity. Thus, a child born in the rural area in Nigeria will absorb magical interpretations of causes and treatments of madness, he will absorb images of madness in the idiosyncratic

coloration given it by his parents (or whatever other individuals are in charge of his primary socialization (Berger and Luckmann 1966). The implication of this is the establishment of an objective and subjective reality with a coherent and continuous identity (*Ibid*). Thus, social constructions of reality are culturally and historically specific. Thus, we are able to examine social constructions critically to make informed judgement about the appropriateness of our values based on the knowledge of reality that lies behind social phenomena (Burr 1998).

In summary, the theory of the social construction of reality emphasises the role of language, experience and social practice in the way reality is conceptualised. The diversity in representations of reality clearly points to truth as a relative component of reality. Reality in African clime is that magically explainable causes have constituted a major model for explaining mental illness. This is the truth as perceived by many and represented in the media. Investigating if the media is responsible for the continued existence of such believe is another reason for an empirical inquiry. However, belief in magic and spiritualism as major underpinnings of interpreting causes and treatments of mental illness particularly in Nigeria may be suggestive that these

conceptions of reality are constructions that the media reproduce from existing constructions that reside in cultural and historical beliefs around mental illness.

6.2 FILM/NARRATIVE THEORY

This study is interested in analysing fictional narratives produced in Nigeria while using western theories to explain some of the structures and elements in the narratives. This is not to imply that film theories have not been adopted to explain narrative structures of films produced in Africa. For example, studies have shown that ‘third cinema’ theory emerged from film related writings that emerged from the ‘third world’ countries (Stam 2000). Third cinema theory as a concept signifies the writings from Asia, Africa and Latin America (Third world) that cohered into a theory in the 1950’s (*Ibid*). As explained by Stam (2000), Third World refers to nations and societies that were colonised, neo-colonised and decolonised. Third World also refers to minority, backward, and underdeveloped nations, influenced by economic and political structures of the colonial process. According to Stam (2000), the adoption of the term, ‘Third World’ empowered nations through attraction to cinematic productions that emanated from Asia, Africa and Latin America.

However, some western film theories have helped to explain the process involved in ways audiences consume cinematic products. Readers or audiences of media texts are required to extract meanings from text, a process psychoanalysis or realism as film theories have endeavoured to explain. Psychoanalysis has shifted from analysing the relation between filmic image and reality to conceptualising spectators as the subject on which cinematic institutions rely (Baudry 1975; Stam 2000). According to Morin cited in Stam (2000), the cinema implicates the spectators in very great depths as an 'archive of souls' that experience powerful emotions as cinematic materials capture the attitudes, movements and desires of the spectators.

The concept of cinematic apparatus as explained by Baudry (1975) involves the setting up of a subject as the active centre and origin of meaning. Baudry explains that images in cinemas are of something that results from a deliberate act of consciousness. Thus, images in the cinema represent meanings of objects that reside in the world of the spectator. A recent criticism of the cinematic apparatus exists in the generalisation of cinema viewers. Reich and Richmond (2015) argue that apparatus theory present viewers as monolithic without considering factors that structurally differentiate

people. Thus, the crux of Reich and Richmond's (2015) argument is that the cinematic apparatus explained the position of spectators as 'ideologically-freighted subject', while suggesting that spectators inhabit the ideology that emanate from film texts.

In addition, Lacan in Stam (2000) argues that language – both in the synchronic and diachronic forms – are fundamental parts of psychoanalysis, which enables better understanding of the different values of transference or resistance that occur during language interpretations of text. Psychoanalysis film theory is employed to explain film as a medium of impressing reality, which Baudry (1975) argues is invoked to avoid the real problems of connecting cinema to subjects. The cinematic apparatus theory explains film through mechanical instrumentation of series of images that represent what often seems like “instants of times and slices of reality” found in the use of movie camera (Baudry 1975). The paradoxical nature of relating the cinematic images to the mirror effect involves the conceptual belief that images in the cinema are reflective of social reality. The mirror effect as a similitude for explaining the relationship between film and its spectators is conceived in the imaginary, symbolic and

real as constituting orders of subjects (Lapsley and Westlake 2006).

“The imaginary comprises the repertoire of images that the subject invokes to annul the original gap, and is present in the mirror phase as the image of the other with which the child identifies and which masks its division. The symbolic, ... comprises the Order of laws, rules, codes and prohibitions, to which the child must submit in order to enter the society ... the real is defined negatively as that which the imaginary seeks to image and the symbolic seeks to symbolise ” (Lapsley and Westlake 2006, p.69).

The relevance of concepts of real, imaginary and symbolic in theorising relationship between films and its spectators appear more meaningful when approached as a collective whole than approaching the order of subjects individually (*Ibid*). Filmic images are representations of the real, which spectators perceive as representative of something other than themselves, but real (Metz 1976). Images and sounds are offered as the imaginary which cannot exist without the symbolic (Metz 1976; Lapsley and Westlake 2006). For film text to make credible sense to spectators there is an imaginary plenitude (perceptions of real) from where images that are symbolic (known to invoke similar meanings in subjects) emerge. The imaginary can be referred to as mental images which film texts translate to real images when

symbols are used to represent the imaginary. The symbols appear in the form of images that the spectators perceive as imaginary just like the reflection in the mirror. The mirror reflections are representations of something real while the reflection in itself is not real (Metz's in Lapsley and Westlake 2006). In the process of interpreting texts, images from filmic texts appear imaginary to the spectators as repertoire of the real and the unreal is evoked to identify how the imaginary symbolises real images. On the one hand, there is the ideological perspective of film text which emphasizes the dominance of certain perspectives over another, which means that film spectators do not respond to images of film text the same way (*Ibid*).

6.3 IDEOLOGICAL FRAMINGS OF MEDIA MESSAGES

In this section, the view that media texts are ideological will be explained. The media is an arena for social groups, institutions and ideologies to construct their own version of reality. Despite the multiplicity of meanings that media texts call to, when symbols, themes, and style are carefully presented to suggest a specific reading of media text, then it can be argued that media texts invite readers to consume its own ideology. From another perspective, media messages are

ideological when powerful structures of a society deploy media texts to influence a subordinate body or class (Price 2005). In this context, media texts have implicit or explicit ideology in the way a coherent position or point of view is composed (*Ibid*). Also, the ideological representations of text are embedded in the way language create deeper meanings, either obvious or hidden, (Fairclough 1995) in media generated images of social and political issues (Gamson *et al.* 1992).

Ideology has been described as a representation of the social identity of a group and is articulated through discourse, cognition and society (van Dijk 2006). Media contents have specific ideas that they intend to express. These ideas, as explained by van Dijk (*Ibid*), come from a belief system that is also known as cognitive component of ideology. Discourse as a fundamental constituent of ideology takes place when belief systems are communicated and shared socially among members of social groups who van Dijk (2006) referred to as social actors. In other words, ideologies are sociocultural knowledge or attitude of a social belief system that are shared for the purpose of control or organisation of social activities. Van Dijk's (2006) argument is that ideology is not a personal belief of an individual person nor does it necessarily have to

be negative or dominant for it to account as an ideology. Ideology may equally reflect the opinion of a minority or oppositional group. It may represent the position of a collective group who share the same interest. Consequently, ideology may also represent the basis for marking a difference between social groups.

Theorists of social constructionism have argued that media generated messages have relational connection with social representations of beliefs, norms, values and knowledge. In other words, media messages are meaningful when texts convey desired meanings to recipients of media messages. However, ideologies of these messages are not apparent or visible at the first readings. So, ideological perspectives on issues permeate discourses when subjective interpretations of situations or events are engaged in by language users through the construction of mental models (van Dijk 2006). Thus, the ideology of media messages can be evaluated from ways media messages are framed. And framings of media texts occur when key ideological groups whose motive to become dominant; suppress dominant views; or articulate oppositional views or minority voice, force them to produce media texts in certain ways to evoke specific meanings. An ideological analysis of media messages may reveal that some

major components of language use: images, absence or presence of specific images, the use of specific words or lexicons over other options, intonation, language pace, colour separation, presence or absence of aesthetics, genre of music, headlines and arrangements of picture sequence, to tell a story are formations and structures that impact on how media messages are read and understood. Thus, ideologies are expressed and reproduced in discourse and communication texts, including non-verbal messages such as pictures, photographs and movies (van Dijk 1995a).

“Ideologies are localised between societal structures of the minds of social members. They allow social actors to ‘translate’ their social properties (identity, goal, positions, etc.) into knowledge and beliefs that make up the concrete models of their everyday life experiences, that is, the mental representations of their actions and discourse” (van Dijk 1995a, p.21).

Ideology as a theoretical tool for analysing media messages has met with concerns and arguments involving how questions of usage as a theory can, “supplement or replace existing range of approaches to the way meanings and values, including emotions and aspects of imaginative life, are analysed and understood” (Corner 2016, p.265). Corner argues for a difference in the way ideology is conceptualised by political scientists - to explain social issues in relation to

power, meaning and subjectivity – and the way media constitute and represent ideology. According to political scientists, ideology is used descriptively as a body or system of beliefs from which a political community hold varied identities (*Ibid*). As far as Corner is concerned, ideology has not established itself in international media research, simply because its approach has been more descriptive than critical. In engaging Downey's (2008) point of view on ideology, Corner (2016) argues that for ideology to match the requirement for theoretical framework that critically analyses power relations in media texts and social beliefs, subjective recognition and misrecognition; balance between sociological and psychological analysis; and incorporation of knowing in relation to just feeling in the way historical specificity of social issues are analysed is required. And for this to happen, Corner (2016) argues that framing as a way of exploring the distribution of salience and marginality in political and economic narratives will be employed for analysing media thinking.

In addition, Downey and Toynbee (2016) argue that contemporary media studies lack the adoption of a critical concept of ideology to guide academic analysis and political practice. Arguing that a communicative system has to be

deceptive for it to be ideological is irrelevant, but the internal composition of a narrative or media text is crucial to critically discern the ideology of a message (Downey and Toynbee 2016). A common area of ground that has been reported in the theory of ideology across many subjects is that texts and talks have intended meanings that are suggested in the way communicative elements are interpreted and understood. In the communicative processes, the intended meanings structure the decision made on lexicon, semantic and pragmatic composition of texts. The textual composition represents clusters of facts that are thematically reinforcing (Entman 1993) and representative of intended ideas. However, the selection process influence the structuring of messages to enforce specific readings, which invariably implies that messages have to be framed before stating critically that a message, is ideological.

Therefore, framing theory can be described as offering a way of comprehending the power of a communicative text through selection and salience (Entman 1993).

“To frame is to select aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation,

and/or treatment recommendation for the item described” (Entman 1993, p.52).

Framing in a communicative process involves the communicator – the one who decides what to say and how to say it either consciously or otherwise; the text – which in itself contains the frame or ideological theme; the receiver – the one who is required to decode the frames either as intended by the communicator or not; and culture – the stock of all possible frames that can be invoked (*Ibid*). However, Entman’s (1993) concept of framing has been critiqued by Scheufele (1999) who argues that framing should be approached from a more meta-theoretical perspective due to its operationalized extension to other media effects theory such as agenda setting or priming. Schuefele may be right as Entman (2007) argues further that agenda setting is indeed the first function that framings in media texts seek to fulfil, while priming is the intended effect of framing elements in media texts.

6.4 UNDERSTANDING MENTAL ILLNESS THROUGH DISCOURSE ANALYSIS

Discourse as a theory evolved from structuralism in the 1960’s to ideology and then discourse (Macdonell 1986). Discourse is one of the many theories that have been adopted

to explain ways knowledge correlates with reality. Knowledge as a basis for a credible discourse has theoretically been argued to emerge from experience (empiricist epistemological point of view); logical order of conceptual thought (rationalism thought); or history (archaeology) (Macdonell 1986; Fairclough 1995). Fairclough (1995) refers to discourse as a representation of written and spoken language use; semiotic activities such as visual images; and nonverbal communication that produce meanings. Discourse analysis has become an attractive research tool for challenging and questioning social practises and saying something about how somethings could be done differently.

Fairclough (*Ibid*) describes the approach to discourse as 'critical' when analysis, which results from the belief that many texts have their political and symbolic sense (Price 2007), is done to create connections between texts, social properties and ideological implications that text readers are usually oblivious to. For instance, can portrayals of mental illness in the media be said to constrain or facilitate a particular action towards mental health issues? Discourse analysis can be deployed to provide the answer to the above question because of its integral feature of foregrounding link between social practise and language; and systematic

investigation of connections between properties of social processes and language texts (Fairclough 1995).

“Discourse models are our 'first thought' or taken-for-granted assumptions about what is typical or normal, since the world is infinitely full of potentially meaningful patterns and sub patterns in any domain, something must guide people in selecting which patterns or sub patterns to focus on... And this something resides in the Discourse models of the person's sociocultural groups and the social practices and settings in which they are rooted” (Gee 2005, p.68).

Discourse analysis is an approach that can be deployed for explaining and putting social and cultural change into proper perspective (Fairclough 1995). For example, mental illness evokes varied understanding in cultures, languages and social settings. The term madness does not evoke the same interpretation and understanding as it did in the period of pre-modernism, modernism and post-modernism (Macdonnell 1986; Gilman 1988; Cross 2010). Thus, ‘one could know about madness and folly in the eighteenth century’ (Macdonnell 1986, p.82); today one can know about mental illness (Foucault 1965; Porter 2002). Language has made the preservation of changes in history of madness possible. Also, history makes discourse possible as there are no boundaries

to what can be referenced from interpretations of madness in the past and present.

Discourse focuses on social happenings as it relates to people who happen to be the source of history. Gee (2005) describes discourse as a way of integrating and combining language, actions and interactions; and a way of thinking, valuing and using various symbols to enact a particular sort of socially recognisable identity. The socially recognisable identity therefore forms the knowledge base from where meanings of signs and symbols are understood within a social context. For example, borrowing from Fairclough's (1995) breakdown of salient aspects of discourse, there are three levels of discourse in spoken and written texts. The first aspect is reporting or representing discourse and analysing mental illness in situated social groups: meaning that real interpretations of madness as understood by social members are explained. The first discourse paves way for the second discourse, which involves the represented and reported discourse. The second discourse involves explaining ways reported madness in social interactions, texts, and images reflect general perceptions of madness. And the third discourse entails determining ways society attribute

importance to reported and represented discourses of madness by analysing madness in situated social contexts.

Thus, Critical Discourse Analysis make analysis of media representation of mental health issues in Nigerian context possible through a breakdown of media portrayals into texts – oral and visual; discourse practice – processes of text production and consumption; and socio cultural practices (Fairclough 1995). Cinema, television, photography or paintings as forms of media may not reflect the world in direct ways but may construct representations of the world using complex set of conventions that sometimes have hidden meanings (Allen 1987). Hidden meanings here do not imply that the texts become difficult to understand as text or image of something, rather each cinematic, televisual or literary work is seen as a distinctive reordering of existing codes and symbols deployed to suggest specific meanings. Thus, discourse analyses provide a basis for deploying salient tools for deconstructing hidden or apparent meanings in media portrayals of mental health issues.

CHAPTER SEVEN

RESEARCH METHODOLOGY

Research methodology is an argument to justify the approach that will be employed to answer conceptualized research questions (Jankowicz 2013). In this study, the two major techniques for data gathering – selection of movies and evidence of interview respondents - involved purposive selection of samples. Samples were purposively selected on account that people chosen have views that are relevant to the study and typify important varieties of viewpoint within the population (Jankowicz 2013). In the bid to achieve the set aims of this study, this work was approached from the ‘constructivist’ point of view. This research is an empirical study that contributes to knowledge through interpretation of themes, patterns and events that emerged from the data. Results from both research techniques were compared. The interpretive approach to this study is Critical Discourse Analysis. Critical Discourse Analysis (CDA) is a highly context-sensitive approach, which takes an ethical stance on social issues with the aim of improving that particular society (Fairclough 1995; Huckin 1997).

The essence of this study is to investigate and identify themes of mental health issues represented in selected movies; and in interviews of key important persons. In gathering data, different techniques were employed in this work. The techniques involved content analysis of movies; and semi-structured interview of selected participants. Numerous research works have investigated media representation of mental health issues using data gathered from different techniques (Philo *et al.* 1996; Rose 1998; Aina 2004; Knifton and Quinn 2008; Demyan 2009; Atilola and Olayiwola 2011a). The focus of this media study is on the content of movies particularly as a media form. This is not to conclude that other forms of media - like the radio, print and internet - do not depict themes of mental health importance. Analysis of media representation of mental health issues in other media forms can be investigated in future research.

7.0 DATA ANALYSIS OF MOVIES

This study focused on mental health issues as identifiable themes in Nigerian movies. The systematic inquiry into the content of media texts in this study required the creation and adaptation of a coding scheme. This process was guided by the objectives of the research, combined with insights gained

from earlier researches that have investigated media representations of mental health issues (Philo *et al.* 1996; Aina 2004; Atilola and Olayiwola 2011a; 2011b; Whitley and Berry 2013). Inclusion and exclusion of some media contents as ‘mediators’ of mental health themes in this study relied on prior knowledge that these movies depict themes of mental illness. The development of coding scheme for analysis of movies and interview were aimed at analysing: (1) the extent of media coverage of mental health issues in Nigeria, with a particular focus on fictional narrative representations of this topic; (2) the content of the movies identified in order to identify emergent themes and narratives that these programmes contain; and (3) the perception of professionals, movie producers and professional mental health care providers, on media representation of mental health issues.

Several bodies of literature (Philo *et al.* 1996; Atilola and Olayiwola 2011; Whitley and Berry 2013) have examined frames and themes of mental illness in movies produced in many countries. The research by Philo, McLaughlin and Henderson (1996) that was carried out in the United Kingdom involved the analysis of media content and the categorisation of mental health themes into five distinct sets: a) comic images, b) violence/harm to others, c) violence to self, d)

prescriptions for treatment/advice/recovery, and e) criticisms of accepted definitions of mental illness. The media sample they analysed focused mainly on news reports, fictional television, popular magazines and children's literature from a range of local and national media output (Philo *et al.* 1996).

Philo *et al.* (1996) categorised themes of mental illness into fictional and factual representations of mental health themes in the identified media. The factual representation looked at real life reports in the news - either on the television (BBC or ITN) or in the tabloids - with reported events that made reference to the mentally ill directly or indirectly, using clinical/technical terms such as 'psychosis' or 'dementia', and in popular language use of 'deranged', 'psychopath', and 'maniac'. The fictional representations as investigated by Philo *et al.* (*Ibid*) looked at soap operas or medical dramas, children's fictions, and women's magazines and came to a conclusion that the bulk of media contents situate mental illness in violence or danger and presents the public as potential victims of attack from the mentally ill (Wahl 1992; Rose 1998).

In a recent study that expressed lessons learnt from analysing media representations of mental illness in a national project, Whitley and Berry (2013) developed a coding scheme that consisted of three different parts: a) the descriptors; (b) objective questions – what narrative form is adopted by the media; are people with mental illness quoted in the text of the media directly or indirectly; and are mental health interventions discussed in the story; and (c) the subjective questions - is the overall tone of the story optimistic or positive about mental health; and is the story stigmatising in tone and/or content? The work by Whitley and Berry (2013) involved the analysis of media portrayals of mental illness in Canada on a large scale within a period of two years. The aim of their work was to enhance further research into the area of media representation of mental health themes by providing basic information on a well-grounded pathway to analysing media content for mental health representations.

Another research project that inspired the creation of a coding scheme for this work was carried out in Nigeria by Atilola and Olayiwola (2011a; 2011b). The focus of their research was to explore the frequency and modes of framing mental illness in Yoruba language genre movies. Movies

produced in Yoruba language and sourced from three rental shops in three local government areas in Ibadan (the third largest city in Nigeria and the one with the largest geographical area) were identified for analysis by the researchers. Atilola and Olayiwola (2011) adopted a check list of frequent themes that are used in the description of mental illness in movies. Highlighted themes that featured as symptoms of mental illness in the movies included: gender confusion, suicidal ideation, low mood, hallucination, delusion, interpolations of thought, incoherent and irrelevant speeches, regressed behaviours, talking and laughing to self, poor grooming and dressing, vagrancy and hoarding. The result of this investigation by Atilola and Olayiwola (2011) showed that twenty seven (27) films from a list of 103 films analysed by the researchers had scenes of mental illness; twenty one (21) of which were implied by the film directors; and six (6) of which were not implied but presented themes of mental health.

The most commonly depicted aetiology or causes of mental illness in these movies were enchantment from witches and wizards: where “vivid fetish gyrations and incantations were directed at victims for reasons that ranged from jealousy to rivalry” (Atilola and Olayiwola 2011, p.167). The treatment

modalities with the highest representation were magical and spiritual healing from diviners and religious priests. Evident in the movies were attributions to successful magical intervention, even in situations that present the mentally ill as suffering from the illness for many years. In sum, the study by Atilola and Olayiwola (2011a) showed that scenes depicting mental illness are quite common in the Yoruba language genre movies.

Atilola and Olayiwola's study (2011a) focused on images of mental health in the Yoruba language genre, but this present study included English language genre movies in its analysis for a robust understanding of possible similarities and differences that exist in themes of mental health that reside in narrative plots. A point of enquiry here however, is to know if variance in languages adopted in the rendition of a story effect significant difference(s) in the manner at which themes of mental illness are presented.

Going further in this study, the investigation of frames of mental health issues in English language genre movies included verifying earlier submissions on mental health themes in Yoruba language genre movies; and the

identification of new mental health themes that are unique to the English language genre movies. Similarly, the comparison of this research outcome with those carried out in other cultures will help in understanding how media representations of mental health themes in the Nigerian context correlate or differ from themes of mediated mental health in other cultures - such as those associated with the United Kingdom, America and Canada (Wahl 1992; Philo *et al.* 1996; Knifton and Quinn 2008; Maier *et al.* 2013; Whitley and Berry 2013).

The process that enhanced movie selection involved identification of Yoruba or English language genre movies that have a list of mental health themes that must be present. Unlike the work of Atilola and Olayiwola (2011), the interest of this study is more on movies that deliberately depicted mental health themes. The selected mental health themes that were used for analysis are a summary of basic symptoms that experts argue are common features of mental illness. The fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994) was used as a reference point for this purpose. The themes of mental illness that were looked out for in the movies include one or more of the following:

1. Vagrancy
2. Hoarding
3. Unprovoked aggression
4. Over elation
5. Suicidal ideation
6. Low mood
7. Hallucinations [auditory or visual]
8. Delusions (clouding of consciousness, Interpolations of thought)
9. Incoherent and irrelevant speeches - statements that do not make psycho- dynamic sense
10. Regressed behaviour (behaviour that is not consistent with socially accepted manner of talking, acting and living)
11. Hysteria (talking and laughing to self)
12. Unkempt appearance (poor grooming and dressing, untidy hair)
13. Angry/ irritable mood
14. Defiant behaviour

15. Disorganised speech

16. Grossly disorganised behaviour

Based on some selected descriptors of mental illness that have been mentioned above, ten movies were selected. The chosen movies were produced in years 2013 and 2014. The movies selected were not movies produced specifically about mental illness. However, the selection was based on story lines of movies that featured mentally ill character(s). Some of the movies were accessed on video compact disc (VCDs) - based on their availability, while others were accessed on the internet. The movies selected were those with instances of mental illness, such as depictions of causes of mental illness in mentally ill characters and treatment modalities adopted in these narratives. The movies were analysed with the aim of investigating:

- a) The narrative forms of the movies;
- b) The portrayal of the mentally ill as identifiable individuals or communities;
- c) The ways in which the causes of mental illness were identified within the narratives;
- d) The cinematic portrayal of mental health care; and

- e) The appearance or otherwise of stigmatization as a theme.

Specific categories and sub-categories were developed to enhance a systematic content analysis of the movies with depictions of mental health themes. The Nollywood movies examined in this study were taken from both Yoruba and English language genres. The movie selection process involved choosing previewed movies with mental health themes released for public viewing in years 2013 and 2014. Movies with mental health themes that flow into two parts were categorised as two separate movies in this study. In cases where mental health themes were present in only one part of a film with two parts, the part of the movie with mental health themes was analysed.

7.1 DEVELOPED CATEGORIES AND SUB-CATEGORIES FOR MOVIE ANALYSIS

The identification of movies with themes of mental illness concluded the first phase of content analysing movies. However, the second phase of content analysis required allocating certain themes to specific categories and sub-categories. The developed categories, sub-categories and codes further enhanced a critical discourse on analysis of

movie contents; emergent mental health themes; and narrative structure and elements of the movies. The list of categories, sub-categories and codes are available in Appendix E.

7.2 TECHNIQUE USING DATA FROM MOVIES

Ten movies produced between 2013 and 2014 were purposively selected based on prior knowledge of their depiction of mental health scenes. Six of the movies selected were produced in Yoruba language (one of the three major languages spoken in Nigeria); and the remaining four movies were produced in English language. The Yoruba language movies selected had English sub-title features. The rationale for adopting this technique is to identify themes, events and expressions of mental illness in movies; and to show how identified themes, events and emotions evoke thoughts, beliefs, and patterns that represent social belief in mental health issues. This study seeks to explain ways mediated mental health themes represent images that interact with existing stigma.

Previous works have confirmed the proliferation of movies among Nigerians (Chapter Three). Many Nigerian movies are available on the internet for free viewing and download; and in indigenous languages, which may enhance the segmentation of audiences. An example of this view is found in the fact that nine (9) out of the ten (10) movies analysed were sourced from the internet. The inhabitants of rural areas may not have access to these movies on the internet but their affordability and availability creates an avenue for rural dwellers to have access to indigenous movies.

Content analyses of selected movies were carried out with the hope of identifying themes of mental health ‘stigma’, ‘discrimination’, ‘negative representation’, and ‘positive representation’. However, there are limitations to this choice of method. The movies analysed were not randomly selected from a list of movies produced within the year under review. This is attributable to poor availability of a decent archive that can be consulted for a list of movies with depictions of mental illness. This left the researcher with the option of sourcing for accessible movies that still fell within the criteria stipulated for selection of movies for analysis.

7.3 NARRATIVE PLOTS OF MOVIES ANALYSED

In this section, the narrative plots of movies have been provided. The essence is to facilitate comprehension of the analysis of movies contained in the next chapter. In this section, basic information like the internet URL and specific year of publication of each movie have been excluded, but are made available in Appendix D. In breaking down the plots of the movies, care has been taken to provide adequate description of salient scenes that confer meaning on the overall narrative.

Movie One: *Egwonga* (The Deadly god) (2014)

Director: Greg Chyke Inawodoh

Genre: Drama (English language movie)

Distribution: this movie was available in VCD, internet (e.g. YouTube), and for internet download. The viewership on the internet was 20,936 as at year 2014 when this movie was analysed. However, it should be noted that the viewership recorded here is exclusive of the number of views on VCDs and at the cinemas. The movie *Egwonga* (the deadly god) is the continuation and concluding part of the movie titled *The Bleeding Tree*. Though, the depiction of mental illness

appeared in the Egwonga part of this movie franchise, the summary of the story will begin from *the bleeding tree* for a coherent overview of the narrative plot and this is provided in Appendix G. The movie *Egwonga* is a story of a young woman who became mentally ill because an ancestral god (Egwonga) insisted on having her (Oruigo) sacrificed to appease him for deviating from an oath Oruigo's mother took with the god (Egwonga). In the plot of the movie, the causes and treatment methods suggested were indicated.

Movie Two: Aso Were (madman's cloth) (2013)

Director: Segun Ogungbe

Genre: Drama (Yoruba language movie)

Distribution: this movie was available on VCD and internet for views and downloads. The viewership on the internet as at year 2014 when this movie was analysed was 135,969, which is exclusive of VCD and cinematic view.

This movie was split in two parts of *Aso Were 1* and *Aso Were 2*, but the first part with themes of mental illness is the only part that was examined in this study. The plot of the movie was about the use of a cut piece of a madman's clothing to

attempt to magically change a female foetus to a male. Please refer to Appendix G for an in-depth summary of the plot.

Movie Three: *Obiripo* (what goes around comes around) (2013)

Director: Antar Laniyan

Genre: Drama (Yoruba language movie)

Distribution: this movie was available on VCD and for viewing and download on the internet. The viewership on the internet as at year 2014 was 79,109, which is exclusive of VCD and cinematic views.

The movie told the story of how a young man lived life with the pain of hiding the news of his mother's mental illness from his wife; the reaction of his wife after knowing about of his mother; and the ensuing causes and treatment of mental illness in two characters that were suggested in the narratives. A detailed description of this movie is provided in Appendix G.

Movie Four: *Tears of madness* (part one) 2013

Director: Okey Zubelu Okoh

Genre: Drama (English language movie)

Distribution: this movie was accessed on VCD only. Attempts to view this movie on YouTube were futile but some other internet sources had it available for download. Viewership was not accessible as this movie was not available on YouTube, and access to VCD or cinematic views is not readily available.

This movie was produced in English language and the Igbo culture was backgrounded in the narrative. The movie plot was about a woman who became mentally ill after the loss of her child and the support and care she received from her husband. More description of this story is provided in Appendix G.

Movie Five: Tears of madness (part two) (2013)

Distribution: This movie was accessed on the internet and was available on VCD. The viewership of this movie on the internet was 107,123 numbers as at 2014 when this movie was analysed. This analysis is exclusive of VCD and cinematic views, which are readily not available for all the movies.

In the second part of this movie, the lost and vagrant mentally ill character (Somadina) became pregnant, gave birth to a boy and was finally reunited with her husband who was instrumental to her total cure from mental illness. Please refer to Appendix G for an in-depth summary of the plot.

Movie Six: *Elulu* (part one) 2014

Director: Nurudeen Majeed

Genre: Drama (Yoruba language movie)

Distribution: this movie was accessed on the internet in year 2014. However, later attempt to access the same movie on the stored URL showed that the movie was taken out and republished on another URL in 2016. Thus, the breakdown of internet viewership (2,537) of this movie implied viewership from year 2016 instead of the initial year of publication (year 2014)

This movie was about a mentally ill man (Gbeminiyi), his relationship with a woman (Ojuolape) who fell in love with him despite his state of health and her travails in convincing everyone on the rationale behind her decision. More description of this movie can be found in Appendix G.

Movie Seven: Elulu (part two) (2014)

Director: Nurudeen Majeed

Genre: Drama (Yoruba language movie)

Distribution: the distribution analysis of the second part of this movie is the same as the first part. However, viewership analysis suggests 3,624 views, exclusive of VCD and cinematic views, due to republication that was done on the internet years later.

This movie part is the continuation and conclusion of the movie and it unfolds the mystery that led to Gbeminiyi's mental health issues, and the treatment suggestions that were offered as explanations for Gbeminiyi's full recovery. Please refer to Appendix G for an in-depth summary of the plot.

Movie Eight: Mad Couple (2014)

Director: Tchidi Chikere

Genre: Drama

Distribution: this movie was accessed on the internet in year 2014. This movie was later taken off from the URL address it was initially accessed on and later republished on another

URL address. Thus, the viewership analysis (10,737) may not reflect the estimate from the exact date of first publication and simply because this data is exclusive of possible VCD and cinematic views, if any.

This movie is about a brilliant young woman, a student of medicine and pauper, and her travails with a resentfully jealous friend, a very compassionate friend, sufferings from mental illness and academic stress.

Movie Nine: Ore Meta Were Kan (part two) (2014)

Director: Adebayo Tijani

Genre: Drama (Comedy); Yoruba language movie

Distribution: this movie was published on VCD and internet, but was accessed in 2014 on the internet. Viewership on YouTube suggests 110,959 views, which is exclusive of VCD and cinematic views.

The movie is about three poor and greedy friends: Akanni (Muyiwa Ademola); Ajani (Wale Akorede); and Ige (Olaniyi Afonja) who made ceaseless effort to become rich. The movie emphasized the encounter of the three friends with a madman who turned out to be the source of Akanni's wealth and facilitator in resolving the mystery that surrounded the

death of Akanni's mother. More description of the movie can be found in Appendix G.

Movie Ten: *Ire Aje* (2014)

Director: Soji Eweade Innocent

Genre: Drama (Yoruba language movie)

Distribution: this movie was made available on the internet and VCD. For analysis in this study, the movie was accessed on YouTube and the movie recorded a viewership of 10,745 as at 2014 when it was analysed. This figure is exclusive of VCD and cinematic views.

Ire Aje is the story of a man (Akanji) and the numerous problems he encountered due to his marriage to a mentally ill woman. In this narrative, Akanji took good care of his wife and later found cure for her mental illness when an Ifa priest revealed the connection that existed between Akanji's father, and the emergence of mental illness in Akanji's wife. More description of this movie can be found in Appendix G.

CHAPTER EIGHT

CINEMATIC NARRATIVES:

8.0 ANALYSING MOVIE CONTENTS

In the analysis of movies, five broad categories were developed to investigate portrayals of the mentally ill as identifiable members of a social group; ways in which causes and treatments of mental illness are presented; and appearances or otherwise of stigmatic themes. Stigmatic themes included portrayals of mental health issues that may influence negative cognitive and behavioural disposition towards the mentally ill. Stigmatic themes are looked out for in depictions of the mentally ill as perpetrators or recipients of various forms of violence; the presence of social distance; and exaggerated representations of symptoms of mental illness.

Ten movies were analysed and the results are available in this chapter. The tabular analysis of the movies is available in Appendix III. The movies were analysed independently using a coding scheme that was developed by the researcher. A simple process of indicating the appearance of images that

fall into each identified theme using frequency distribution influenced the quantitative analysis of the media texts.

8.1 BASIC DESCRIPTORS OF MENTAL ILLNESS IN MOVIES

8.1.1 Gender Representation

A total of thirteen mentally ill characters were represented in the ten movies analysed. From a total of thirteen mentally ill characters, they were eight female characters (61.5%) and five male characters (38.5%). There were four mentally ill female characters in the Yoruba and English language movies each. All five mentally ill male characters emerged from the Yoruba movie genre, thus suggesting that English language movies rarely present mentally ill male characters.

8.1.2 Social Status

In understanding how the movies emphasized the social status of mentally ill characters, reference is made to the educational status of mentally ill characters, which was then analysed. Level of education here cut across investigating how mentally ill characters were implied as educated or not educated within the narratives, which includes instances

where deliberate reference to education was not implied in the narratives. Exploring the level of education in this study focused on the characterisation of the mentally ill as educated or not in view of perceptions that the educated are more vulnerable to mental illness, as suggested in studies that relate genius to mental illness (Lavis 2005). Also, included in the analysis of the social status of mentally ill characters are references made to being disabled and mentally ill at the same time. The intent here was to investigate if mental illness is understood within the context of disability. The contextualisation of mental illness within disability can be found in countries such as America (Mechanic 1998) and United Kingdom (Watson 2004).

In a total of thirteen mentally ill characters, 46% (n= 6) had their level of education implied in the narratives. The seven characters with no reference made to education in the narratives enhanced better understanding of the level of importance movie directors attach to relating education to representations of mental illness. Reports from Gureje *et al.* (2005) showed that the level of education people have did not correlate with the poor knowledge of psychiatry among people. However, Atilola and Olayiwola (2011) argued that regardless of the educational level of Nigerians, a large

number still believe in preternatural causes of mental illness. In this study, the movie *Egwonga* and *Obiripo* featured three uneducated characters (23%), which equal the number of educated mentally ill characters in the movies. Two female characters were presented as educated in the movies *Tears of madness 2* and *Mad couples 2* (English language genre movies); and one male educated character was presented in *Elulu 1*. From the result, it is suggested that no significant difference occur in the way English and Yoruba language genre movies choose to relate education to mental illness. In English and Yoruba language movies, the character of the mentally ill in the overall structuring of the narrative appear to influence ways references are made to level of education and mental illness.

However, the absence of a deliberate reference to education as a functional part of defining mentally ill characters in narratives made the researcher exclude some movies from the list that indicated the educational status of the mentally ill. For example, in the movies *Egwonga* and *Obiripo*, the mentally ill female characters were portrayed as uneducated. What the researcher looked out for was presence of deliberate reference to educational status as reasons for retaining specific beliefs about mental illness in the films. However, in

all the movies that reflected educational status, foregrounding education in relation to the mentally ill in the narratives did not necessarily determine adopted mental health causal or treatment explanations. In the movie *Mad Couples 2*, the mentally ill character (*Chiamaka*) was portrayed as a brilliant student of medical sciences. The movie offered explanations of causes from alternative point of view (magical infliction of madness on *Chiamaka* by her friend, *Chibuka*); and excessive studying, an explanation that was offered by the medico-science reference in the movie.

In other words, correlation between educational status of the mentally ill and beliefs held of causes and treatments of mental illness have not been established in this study. What is evident in this study is that the level of education of the mentally ill has no impact on the following; the extent of suffering from mental illness; the explanation of causes of mental illness; and the treatment options that may be considered for the mentally ill.

8.1.3 **Disability and Mental Illness**

For the disability status of the mentally ill, no reference was made to physical disability leading to or resulting from mental disorders in any of the movies analysed. This lends support to the report from UK on disability and mental health discourse, which states that a clear agreement between mental and bodily impairment has been attempted, but has not been achieved (Beresford, Harrison and Wilson 2002). In an analysis of the *American with Disability Act* (ADA) of 1990 in America, sufferers of mental disability enjoy benefits from social policies that are targeted at people with physical disability (Mechanic 1998). The interest in investigating the relationship that may exist between physical disability and mental illness is in the identification of cultural meanings of disability that may be found in perceptions of mental illness in the Nigerian context. The isolation of mental disability from the concept of disability in movies studied is suggestive of a lack of a specific relationship between disability and mental distress in Nigeria.

8.1.4 **Reference to Economic Status**

The economic status of mentally ill characters in the movies showed that no mentally ill character worked to make a living

while suffering from mental illness. This analysis is representative of the notion that sufferers of mental illness are incapable of working at a job. By implication, reference made here is to the economic status of the mentally ill at the instance of mental impairment inhibiting ability to work. This position is exclusive of the otherwise economic status of the mentally ill as a member of a financially comfortable family. This result may differ from reports from further empirical study that seeks to investigate how the mentally ill is portrayed as working at jobs at the lapse of mental illness. An interpretation that surfaced from the depiction of the mentally ill as unfit for economic activities in the movies, points to a notion that perception of mental illness as an inhibitor to engaging in economic activities exist. In the study, sufferers of mental illness were portrayed as presenting symptoms of severe mental disorder as against a more subtle display of mental illness that may still allow the sufferer to engage in social functions - such as working at a job.

8.1.5 Role of the Characters

A large number of the mentally ill characters in the movies analysed occupied lead roles (38.4% = 5). Representation of

mentally ill characters in supporting roles was similar (n= 4, 30.8%) to the number of characters in minor or featured roles (n=4, 30.8%). Four of the mentally ill characters in the lead roles were from the English language genre movies (*Egwonga*, *Tears of madness 2*, *Tears of madness 1* and *Mad couples*); and one was from the Yoruba language genre movie (*Elulu 1*). All four mentally ill characters in supporting roles were from the Yoruba language genre movie (*Ore meta were kan*, *Obiripo*, and *Ire aje*).

The number of mentally ill characters in the overall movies were thirteen (n= 13, 100%). There were 69.2% (n= 9) mentally ill roles in the Yoruba language genre movies: one in lead role; four in supporting role; and four in minor roles. The English language genre featured roles of mentally ill characters at 30.8% (n= 4) in the movies. Thus, four English language movies presented four mentally ill characters in lead roles. The narrative structure of the Yoruba language genre movies analysed did not appear entirely different from what was observed in the English language movies. Mentally ill characters in the Yoruba language movies may not have occupied lead roles, but the structuring of the movies reflected the dominance of the mentally ill in mechanisms used to control ways spectators will gain information about

the actions, events and characters in the narratives (Buckland 2010).

8.1.6 Presented Symptoms of Mental Illness

In analysing the prevalent ways movies choose to describe mental illness in characters, a total of fourteen different symptoms of mental illness, guided by symptoms suggested in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994), were highlighted for this study. For example, vagrancy included images of wandering from place to place without a means of livelihood: living in dilapidated buildings and hoarding dirt or residing in land fill or other abandoned areas. In a descending order, the results showed that: vagrancy (92.3%, n=12); unkempt appearance (84.6%, n= 11); mental retardation (76.9%, n=10); regressed behaviour, which includes such actions as eating faeces or drinking urine and over elation (69%, n= 9); incoherence in speech or action and delusion (61.5%, n= 8); aggression and hysteria – state of mental agitation (46.2, n= 6) - were the recurring symptoms of mental illness in the movies. However, suicidal ideation (7.7%, n= 1), low mood (7.7%, n= 1) and hallucination (15.4%, n= 2) featured at lower rates. Subsequently, the movies analysed made no reference to

defiant behaviour, which includes actions of bold resistance to authority or actions of opposition to social forces, as a symptom of mental disorder. Mental retardation as an identifiable symptom in the mentally ill indicated inability of the mentally ill character to perform any cognitive ability required to function well in day to day activities.

The movie, *Tears of madness 1* (English language genre) emphasised ten of the highlighted symptoms of mental illness, while *Tears of Madness 2* (English language genre) presented eight symptoms. *Mad Couple 2* (English language genre) adopted nine symptoms in presenting the characters as mentally ill, while *Egwonga* (English language genre) and *Ore Meta Were Kan* (Yoruba language genre) emphasised seven symptoms. *Elulu 2 and Aso Were* (Yoruba language genre) emphasised six identifiable symptoms of mental illness. The movie, *Ire Aje* (Yoruba language genre) featured two mentally ill characters: the supporting role character displayed four identifiable symptoms; and the minor role character displayed five identifiable symptoms of mental disorder. In the movie *Elulu 1* (Yoruba language genre), the lead role character displayed three highlighted symptoms, while the minor role mentally ill character displayed seven symptoms of mental illness. *Obiripo* (Yoruba language genre)

featured two mentally ill characters that played supporting roles and were portrayed as displaying identifiable symptoms of mental illness at a ratio of 9:1.

In a similar study carried out by Atilola and Olayiwola (2011), symptoms of mental illness in Yoruba language movies, from the most common to the least common, were vagrancy and hoarding of rubbish, poor grooming and dressing, talking and laughing to self, regressed behaviour, unprovoked aggression, incoherent and irrelevant speeches or utterances, interpolation of thoughts, delusion, hallucination, low mood, suicidal ideation and gender confusion. Narratives around mental health themes in Nigeria prefer to project certain symptoms in the characterisation of the mentally ill. A similarity was found in ways symptoms of mental illness were portrayed in the English and Yoruba language genre movies. Similarities in the way images of the mentally ill are constructed across narratives suggest the imposition of certain criteria as symptoms of mental illness, the absence of which renders reference to madness incomplete.

8.2 PORTRAYED CAUSES OF MENTAL ILLNESS

8.2.1 Alternative (traditional/spiritual/magical) Explanations

In analysing the causes of mental illness, none of the movies referred to possession by demons as an explainable reason for the emergence of mental illness. In the study by Gureje *et al.* (2005), causes of mental illness from possession by evil spirits were expressed by a large fraction of respondents from South-Western Nigeria (three Yoruba speaking states specifically). However, the study by Atilola and Olayiwola (2011) did not find possession by demons as causative explanations for mental illness in the movies.

In this study, magical spells or incantation (61.5%, n= 8) from individuals or spirit that possess magical powers of some sort featured as the most common explanation of causes of mental disorder in the narratives. This bears similarity with reported high presence of sorcery and enchantment in represented causes of mental illness in Yoruba language genre movies (Aina 2004; Atilola and Olayiwola 2011). Depictions of God's will as reasons for the emergence of mental illness were not found in the movies analysed. Four Yoruba language genre movies featured

mentally ill characters with causes explained from magical spells/incantation; and two English language genre movies featured two mentally ill characters in the same category. In other words, belief in supernatural causes of mental illness is more prevalent in media representation of mental illness in Nigerian movies.

8.2.2 Scientific Explanations

Science-based causal treatment such as attribution of causes of mental illness to substance abuse, biological or neurological defect, were not found in the movies (84.6%, n=11). This report differs slightly from the result of a community based study that showed that misuse of drugs as causal explanations for mental illness is widespread among South-Western Nigerians (Gureje *et al.* 2005). However, reference to psycho-social and economic factors as scientific explanations of causes of mental illness were represented in two (15.4%) mentally ill characters. The study by Atilola and Olayiwola (2011) reported that some movies refer to severe psychological stress as causes of mental illness. Psycho-social and economic factors referred to in this study included problems with primary support groups (death of or disruption of family – divorce, separation, remarriage); problems related

to the social environment (discrimination, loss of friends, acculturation, and adjustment to life cycle transition-retirement); educational problems (illiteracy, academic problems, problems with teachers); occupational problem (unemployment, threat of job loss, loss of job, stressful work schedule, job change, discord with boss or colleagues); homelessness (inadequate housing, homelessness, unsafe neighbourhood, discord with neighbours and tenants); economic problems (extreme poverty, inadequate finances); problems with access to health care services; exposure to disasters/wars and other hostilities (DSM-IV 1994). In this study, reference to substance abuse was not made in the movies. Biological or neurological explanations as causes of mental illness were also not found in the movies analysed.

Despite the dominance of alternative explanations on causes of mental illness, the presence of some science-based themes might also be an indication that psychiatry constitutes an important part of culturally rooted beliefs of mental health. In other words, in the representation of causes of mental illness in English and Yoruba language genre movies, there exist no significant difference in the directorial perception of causes of mental illness in these movies, either as a response to media demand to produce interesting narrative (Henderson 1996);

or as a structural need to produce narratives that mirror the lived experience of the audience (Coëgnarts and Kravanja, 2012).

8.3 PORTRAYED TREATMENT MODALITIES

8.3.1 Science Based Treatment

Psychiatric intervention as a form of science based treatment modality for mental illness was referenced once (7.7%) in the narratives. The movies *Obiripo*, *Tears of Madness 1* and *Mad Couple* featured: use of medication; and visits to general practitioners as science based treatment options for three (23.1%) mentally ill characters. The similarity in the representation of the two themes may be that the use of medications is associated with visit to hospitals or consultation with general practitioners. Other studies (Aina 2004; Atilola and Olayiwola 2011) carried out in Nigeria to investigate the representation of mental health issues in contemporary movies did not integrate use of medication or visit to general hospitals as variables for the analysis of movie portrayal of science based treatment. The identification of a problem that requires consulting a medical practitioner and use of medication is important in the investigation of perceptions that exist about mental disorder. It suggests the

existence of an aspect of science, which conceptualises 'illness' as an expression of otherness: the absence of the normal and presence of the 'unusual' or 'abnormal'. Meanwhile, mental illness has been recorded to suffer more from stigmatisation bordering on media representation of mental health practitioners (Edney 2004); representation of sufferings of the mentally ill (Maier *et al.* 2013); and more explicit reference to poor prognosis in the adoption of psychiatric treatments (Lammie *et al.* 2010). It appears that studies that may have referenced the adoption of general health practice as an agent of stigma or point of call for the treatment of mental illness, which may naturally occur amidst making decisions of treatment options to be adopted in the wake of mental illness, are not available. Nigeria has a medical policy that allows for the provision of seven primary health centres, thirty health clinics and at least one comprehensive health centre in each local government to attend to an estimated 150,000 to 200,000 inhabitants (Scott-Emuakpor 2010, p.55). Thus, general health care facilities are the most common science based health care facility known to many Nigerians, more than other options of mental institutions. Already, the use of general hospitals do not attract stigma when compared to the use of mental health care facilities. Hopefully, the integration of mental health

services into primary health care services that are made accessible through general health practitioners may reduce the stigma widely recorded and associated with the use of mental health care services (Chen and Mak 2008) like the asylum or mental institutions. This is amidst counter reports that suggest physicians/general practitioners may be more stigmatising than psychiatrist in responding unsympathetically to people suffering from mental illness (Thornicroft, Rose and Kassam 2007).

Furthermore, in the movie *Obiripo*, treatment for the mentally ill character was sought from a hospital referred to as a *Specialist Hospital* where the doctor was shown combining the use of medication with magical spells to cure the mentally ill character (*Wura*). Visits to this form of hospital were referenced as visits to general practitioners in this study. The movie also implied that the doctor was trained for general practice and not psychiatry. Use of asylums or visit to mental health institutions were suggested for two (15.4%) mentally ill characters in two separate movies (*Tears of Madness* and *Elulu 1*). Some of the movies were observed to suggest more than one science based treatment. For example, the movie *Tears of Madness 1* featured visit to general practitioners, use of medication, use of asylums or mental institutions and

home or community based treatments as options for treating mental illness. However, science based treatment (n= 2, 15.4%) has the least representation when put in comparison to alternative treatment modalities (n= 8, 61.5%). The English language genre movies that adopted at least two of the highlighted themes of science based treatments methods for mental illness were *Tears of Madness* and *Mad Couple*. Also, the movies *Obiripo* and *Ire Aje* (Yoruba language movie genres) presented the use of medication and visit to general practitioners as treatment methods for mental disorders before or alongside the use of alternative treatment methods.

8.3.2 Alternative Treatment Options

Counselling and exorcism as treatment devices that spiritualists/magicians or traditionalists use in the treatment of mental illness was not indicated in the narratives. In reference to five (38.4%) mentally ill characters, variables of alternative treatment options were not implied in the movies. The movies with no variable of alternative treatment options are: *Aso Were* – no treatment option was suggested at all; *Obiripo* – a second mentally ill character whose cause of illness was presented as a consequence of magically inflicting madness on the first mentally ill character in the same movie;

and *Elulu 1* – no treatment option was offered for one of the mentally ill characters who played a minor role; *Tears of Madness 1* – the mentally ill character was not shown as receiving any treatment for mental illness; and *Tears of Madness 2* – no treatment method within the remit of alternative treatment was presented as resulting in the recovery of the mentally ill character.

The use of herbs (7.7%, n=1) for treatment; and visits to centres (15.4%, n=2) like the church as options of alternative mental health care practice (in the movies *Elulu 1* and *Elulu 2*) featured in the narratives. The use of incantation, prayers, magical spells (30.7%, n= 4) and magical objects (23.1%, n= 3) as means of treating mentally ill characters were prominent themes of alternative treatments in the narratives. Four movies (*Ore Meta Were Kan*, *Obiripo*, *Elulu 1* and *Ire Aje*) from a total of six Yoruba language genre movies; and two movies (*Egwonga* and *Mad Couple*) in an overall of four English language genre movies analysed in this study emphasised alternative treatment modalities. In other words, the treatment options mostly found in the representation of mental health issues in the media are magical healing methods that involve the use of magical objects or words; spiritual healing in religious centres (Atilola and Olayiwola

2011); and use of herbs (Chireau 1997). These treatment modalities are very important elements of alternative mental health care that has been recorded in this study. Counselling as a practice engaged in by general members of the society; or more specifically by key figures in the practice of alternative treatment – like the magicians and religious cleric – was not found in any of the movies studied. Counselling may be argued to constitute an exclusive practice of science-based treatment, however when it is adopted conventionally by members of a social group who are not trained in evidence-based treatment of mental illness, counselling may assume the status of a cultural practice, adopted as treatment modality like many other alternative treatment options.

8.4 STEREOTYPIC REPRESENTATION

8.4.1 Recovery Status

Movies analysed showed that 53.8% (n= 8) of the mentally ill characters were suggested as recovering fully from episodes of mental distress. Thus, suggesting that full recovery is a theme that the narratives attribute to mental illness. Structural resolution in the narratives was often tied to full recovery in mentally ill characters who are victims or heroes; while persistence of mental disorder in mentally ill characters

was more associated with narratives void of resolution, particularly when the narrative progresses into another part of the same movie title where resolution is finally reached. In the narratives, mentally ill characters were presented as experiencing persistence of disorder (23.1%, n= 3); while one (7.7%) mentally ill character recovered partially.

The treatment modality that led to full recovery of some mentally ill characters was not indicated (53.85%, n= 7) in a large portion of the movies analysed. In the movie *Obiripo*, a mentally ill character for which recovery was not prescribed, became mentally ill as a consequence of or retribution for evil actions. In the movie *Obiripo* specifically, the evil actions was inflicting another character in the same movie with mental illness through magic. In the bid to successfully restore the narrative back to equilibrium (Todorov in Buckland 2010) in the structuring of the movie *Obiripo*, the presentation of *Enitan's* step mother as suffering from mental illness as a consequence for harming *Enitan's* mother with madness, was the movie's way of making moral judgement (Entman 1993) on why recovery was not suggested for the mentally ill (*Enitan's* step mother). In some movies, full recovery was not attributed to either science or alternative treatment intervention for reasons such as natural reversal of mental

illness in individuals that do not deserve to become mentally ill. An example can be found in the movie, *Tears of madness 2*, where the mentally ill character (*Somadina*) recovered fully from severe mental illness after her husband (*Richard*) sang a song during a heightened display of mental illness. Full recovery was suggested in this movie to a spontaneous act of singing a song despite series of failed attempt to heal her using science-based mental health care services.

Partial recovery from science-based intervention was suggested for one (7.7%) character with mental illness. No reference was made in the narrative to partial recovery from alternative interventions. Difference between full recovery and partial recovery in this study is in the full or partial remission of mental disorder respectively. However, attribution was made to scientific intervention as contributing to 23.1% (n= 3) full recoveries recorded in the movies, with alternative intervention (30.77%, n= 4) representing the larger treatment modality that led to full recovery of mentally ill characters in the overall narratives. In other words, movies such as *Aso were*, *Obiripo* and *Ire Aje* - all belonging to the Yoruba language genre - did not refer to recovery of the mentally ill in any form, i.e. the recovery status of the mentally ill character was not implied (38.4%, n= 5). Thus, three of the movies (*Ore*

Meta Were Kan, *Obiripo* and *Ire Aje* that attributed full recovery to alternative intervention belong to the Yoruba language movie category, while one (*Egwonga*) belonged to the English language genre. The movie *Obiripo* (Yoruba language genre) portrayed the mentally ill character as recovering fully from a science based cum alternative treatment modality, while the movie *Elulu 1* (Yoruba language genre) made reference to full recovery from scientific intervention with a later record of relapse. The movie, *Mad Couple 2* was the only English language genre movie that presented full recovery from scientific intervention.

One possible importance of investigating references made to recovery of mental illness in the movies was established in a study carried out in America that showed that portrayals of persons with successfully treated mental illness and drug addiction may reduce the level of social distance American's will desire to have from persons with mental illness or drug addiction (McGinty *et al.* 2015). Recovery status of the mentally ill will be further discussed in the sub topic that looked at positive and negative representations of mental health issues in movies.

8.5 STIGMATIC REPRESENTATION

8.5.1 Violence

Portrayal of the mentally ill as objects of physical assault (30.7%, n= 4); and name calling (13.4%, n= 2) from other characters was evident in the movies. However, violence from mentally ill characters towards other characters was largely not indicated across the narratives (61.5%, n= 8). The representation of economic or social depravation of the mentally ill was not found in the narratives, while sexual abuse was featured in the movie *Ire Aje* only. Some Yoruba language genre movies (*Obiripo*, *Ore Meta Were Kan*, *Elulu 2* and *Ire Aje*) reflected violence towards the mentally ill as a characteristic that is displayed by other characters. Name calling as a theme in this sub category was found in Yoruba language movies (*Ore Meta Were Kan* and *Obiripo*) only. In the evaluation of ways the movies choose to represent forms of violence mentally ill characters inflict on self, it was observed that suicidal ideation and physical harm towards self was slightly evident (7.1%, n= 1).

Violence from the mentally ill towards others in the movies was sometimes provoked; and at other times non-provoked. In the sub category of provoked violence from the mentally ill

towards others, physical assault (38.4% n= 5) was the most implied in the narratives. Sexual abuse and murder was not indicated, while verbal assault featured once (7.7%) in the movie, *Elulu 1*. In the portrayal of physical assault initiated by the mentally ill towards other characters after some sort of provocation, three of the movies with this representation were from the Yoruba language genre (*Ore Meta Were Kan*, *Aso Were* and *Elulu 1*); while the remaining two depictions occurred in English language genre movies (*Egwonga* and *Tears of Madness 2*). Violence from the mentally ill towards others in the absence of any form of provocation emphasised physical assault (38.5%, n= 5) over other themes of violence such as: sexual assault, verbal assault and murder. All representations of non-provoked violence were present in Yoruba language genre movies (*Ore Meta Were Kan*, *Elulu 1*, *Elulu 2* and *Ire Aje*) only. Exploitation of mentally ill characters for economic gains was not evident. However, exploitation of the poor mental state of mentally ill characters for sexual gains was evident in the movie *Ire Aje*.

The use of physical assault to enforce compliance in the mentally ill was represented once (7.7%) in the movie *Ire Aje*. The use of restraints such as chains, ropes or cuffs was adopted for three (23.1%) mentally ill characters. Persuasion

(46.2%, n= 6) as a means to get mentally ill characters to behave in a desired manner featured significantly in the movies. Sometimes, mental illness in characters was expressed as a means to harm other characters magically (30.7%, n= 4). The Yoruba language genre movies; *Obiripo*, *Elulu 1*, and *Elulu 2* presented images that portrayed the mentally ill characters as means to magically inflict madness on others. The use of magic as a means to bestow favour (23.1%, n= 3) by unravelling magical mysteries (*Ore Meta Were Kan*) or as a means to magically enhance increase in wealth (*Egwonga* and *Aso Were*) were emphasized in the narratives.

8.5.2 Other Mental Health Themes

In the movies analysed, mentally ill characters were not referred to as friendly. Depictions of calm and subtle display of mental illness were found in mentally ill characters (23.1%, n= 3). One represented mentally ill character (7.7%, n= 1) showed willingness to get better. The act of blaming the mentally ill for their illness was presented in three (23.1%) representations of mentally ill characters in the movies *Ore Meta Were Kan*, *Obiripo* (Yoruba language genre) and *Egwonga* (English language genre). Benevolence (23.1%, n=

3): an attribute of treating the mentally ill in a childlike manner, was evident in the movies *Ore Meta Were Kan* and *Ire Aje* (Yoruba language genre); and *Egwonga* (English language genre).

Other reactions observed in characters towards mentally ill characters were compassion, acceptance or care (53.85%, n= 7). Four movies that emphasised these themes belonged to the English language genre; and three belonged to the Yoruba language genre (*Obiripo*, *Elulu 1* and *Ire Aje*). Reproach (53.85%, n= 7) as a behaviour that can be observed in other characters towards the mentally ill featured in the movies. Five of these depictions were in the Yoruba language genre (*Ore Meta Were Kan*, *Obiripo*, *Elulu 1* and *Ire Aje*) while the remaining two featured in the English language movies (*Tears of Madness 1* and *Mad Couple 2*). Disgust (15.4%, n= 2) as a cognitive element of reproach and anger, were portrayed as attitude in other characters towards the mentally ill. Fear of the mentally ill characters was represented in the movies (46.2%, n= 6 i.e. five in the Yoruba language genre and one in English language genre); while feelings of pity towards the mentally ill characters featured in three movies (23.1% i.e. two English and one Yoruba language genre movies).

The movies revealed that families and friends suffer from emotional distress (53.8%, n= 6 i.e. four representations in Yoruba and two in the English language genre movies) when dealing with a family member that is suffering from mental illness. Families and friends of two (15.4%) of the mentally ill characters in the movies showed acceptance and care towards the mentally ill. However, economic/financial hardship and social castigation of family and friends of the mentally ill was not indicated in the movies analysed.

8.6 NARRATIVE FORM OF REPRESENTING THE MENTALLY ILL

8.6.1 Narrative Elements

The movies were investigated for the narrative elements producers adopted in the rendition of plots. Narrative elements such as the use of flash forwards; rendition of the plot in a non-chronological method; multi-stranded; and point of view were not adopted in any of the movies. All the movies delivered the stories in a chronological form. Video effects were used in 60% (n = 6) of the narratives, while the adoption of flashbacks was present in 80% (n= 8 of 10) of the movies analysed. The use of video effects in the narratives was to emphasize magical themes in association with

emergence or treatment of mental illness in mentally ill characters. In the movie *Egwonga 2*, the scene where the enchanted tree is shown to bleed as a result of an act of profanation carried out by *Ugomma* (the betrothed wife of the enchanted tree who is forbidden to have any sexual relation with any man), reflected how video effect is activated to emphasize magical themes that reflect sudden infliction or cure of mental illness in narratives. In another scene in the same movie, the appearance and disappearance of the enchanted tree in the form of an image that can be seen only by *Ugomma* evoked meanings that suggested that the enchanted tree caused the emergence of mental illness in the victim.

In this study, all (100%, n= 10) plots of the narratives were delivered chronologically. However, flash-backs have also been recorded as a common narrative element that can be found in the way movies narrate plots around mental illness. However, Buckland (2010) has argued that the chronological effect of a narrative is altered when flashbacks are adopted. He posited that the flashbacks alter the linear order of the narrative thus rendering narration of the plots non-chronological. What may have occurred in this study is the adoption of chronology to establish the cause effect

arrangement of events. Flash backs were majorly adopted to further explain events in scenes, without necessarily disrupting the linear ordering of scenes or events in the narratives. In other words, chronology in this study is an arrangement of events where movie narrations flow through the introduction/beginning, disruption and ends on the attempt to repair or actualise a new equilibrium (Todorov in Buckland 2010). Attempt to repair in the structuring of narratives have been identified in this analysis as an important structural feature in narratives that flow into concluding parts of movies of the same plot, which explains why movies with two parts would not attempt to resolve emergent issues in the first part. Examples are in the movies *Tears of Madness 1*, *Elulu 1* and *Mad Couple 2*. From the perspective of the producers, delay in attempt to repair in narratives can be attributed to the need to retain interest in audiences to want to see the concluding part of a narrative, which is often provided in the second part of the same narrative. In no doubt, narratives that do not adopt the element of returning to the former or new equilibrium as part of the overall structure of a movie will invoke frustration or filmic displeasure (Metz and Guzzeti 1976) in the spectators on the turn of event. In addition, previews and dreams (20%,

n = 2) formed part of the narrative elements that were found in the storytelling process of some of the narratives.

8.6.2 Narrative Structure

From the analysis, all movies had the basic structure of introduction, disruption and recognition, in total agreement with Todorov's view on the structural composition of narratives. As stated earlier, movies like *Tears of Madness 1*, *Elulu 1* and *Mad Couple 2* did not suggest new equilibrium or stability in the structuring of the narratives. Resolution or attempt to repair was evident in all the movies except in the movie *Tears of Madness 1*. The result of analysing how elements of narration follow Propp's postulation of narrative structure in the characterisation of the mentally ill revealed that a large number (80%, n = 8) of the movies depicted mentally ill characters as victims; while 10% (n= 1) was depicted as hero. The mentally ill characters as villains and helpers could be found in 20% (n = 2) of the movies for each theme, while the presentation of the mentally ill as reward was present in 10% (n= 1) of the movies analysed. Reference to the mentally ill as a false hero was not found in any of the movies. The movies, *Ore Meta Were Kan* and *Aso Were*, did not present the mentally ill as victims. The movie, *Ore Meta*

Were Kan presented the mentally ill as a hero while the movies, *Obiripo* and *Elulu 2* presented mentally ill characters as villains. The movie *Ire Aje* chose the adoption of a mentally ill character as a reward for the lead character.

8.7 **DISCUSSION**

In discussing the results from analysis of movie contents, Critical Discourse Analysis will be employed to analyse the discursive meaning of the movies, identify the relations between the texts, and provide explanations and interpretation on how discursive texts relate to social practice. Also, concepts and categories that have been developed in this analysis will be examined here to explore how media texts ‘match’ goodly with themes of mental illness using theoretical frameworks such as ideological framings: the social construction of reality, and narrative theories. Furthermore, discussion on movie analysis will examine the wrongs in movie representations of mental health issues; possible causes of these representations of mental illness; why certain discourses around mental illness and media texts are emergent and dominant; and the implication of this dominance on social transformation.

8.7.1 The Concept of Magic in Movies

From the analysis of movies, magical beliefs as explanations for causes of mental illness occurred in 61.5% (n = 8) of thirteen mentally ill characters; and ten movies with depictions of mental illness. This result is indicative of the existence of magical belief as an important component of perceptions held about mental health issues in movie production. The prominence of magical belief in the culture of producing movies with mental health themes may have occurred due to the assumption that various media mediate reality to spectators (Lapsley *et al.* 2006). If this is indeed true, magical belief in media representations of mental health issues may be construed as reflecting the general perception of mental illness that have deep cultural and historical roots (Cross 2010). This may have been further entrenched by a society that is said to maintain and support magical belief (Aina 2004; Gureje *et al.* 2005) in ways diseases generally; and mental illness specifically is understood. The continued popularity of magical beliefs, despite the existence of psychiatry in Nigeria since the 1950s (Heaton 2013a), confirms the importance of magical belief to Nigerians. Movies produced in the Western culture (Philo *et al.* 1996) clearly present different themes of causes of mental illness. In some of the movies analysed in this study, magic or spiritualism in

the way mental illness is understood emerged from belief in the power of a supernatural being, whose authority is manifested through men, women, gods, or deities, and deviance from whom may cause mental disorders. Witchcraft falls under magical belief and the root of magic is in the belief that events can be controlled; and reality impacted upon by means of mental products such as wishes, images, words, and symbolic gestures (Bieńkowska 2009).

Representation of alternative treatment options in the movies also revealed that, for reasons empirically confirmed, content producers of narratives reflect the belief that incantation, prayers, use of herbs and magical objects (magic wands or amulet) by agents of magical powers - such as the priests - are more effective ways to treat mental illness. Herbs used for treatment in many of the movies were commonly from natural materials endowed with spiritual efficacy (Chireau 1997). Treatment of mental illness from the magical or spiritual perspective is an aspect of mental health that scientist have not proven works but, keeps surfacing in narratives that target the educated and uneducated members of Nigerian society, almost confirming the notion that magic or spiritualism is strongly embedded in realities; while logical thinking is adopted only in education settings (Subbotsky

and Quinteros 2002). The effect these depictions may have on the belief system around mental health among Nigerians may be uncertain. However, it can be assumed that the continued suggestion that mental illness can be caused and treated through a supernatural effect created by some gods, demons or magicians (Bieńkowska 2009) may affect the perception people have about mental health care. The narratives, therefore, put psychiatry or science-based mental health mode in a non-existing position or as a less effective option due to poor references that were made to psychiatry in the movies. In other words, magic was and still is a social-cultural way of understanding mental illness. Also, the explanation of causes of mental illness from the point of view of demonic possession may be a fading theme in ways mental health is understood within the Nigerian culture, as reference to demonic possession in the explanation of causes of mental illness was not found in any of the movies. Demonic possession has been included in the variables that were measured in this study because demonic possession is conceived an existing social perception of causes of mental illness in the Nigerian culture.

In this study, the view that media portrayals of mental health reflect producers' perception of mental health has been

emphasized. There exist alternative ways of representing mental health issues, different from the preferred reference producers make to magic and supernaturalism. Hence, magical themes may remain predominant in media representations of madness until content producers willingly adopt alternative themes in narrative plots. The lack of reference to exorcism in treating mental illness may be attributable to lack of themes of demon possession, indicative of an absence that suggest less prominence of such belief. However, since the number of movies analysed did not include all possible movies with mental health themes, this result may not be generalizable.

The focus of this study is not to demean a particular social practice, but to highlight the salient composition of some social beliefs and practices that fail to provide knowledge on how to attend to the issue called madness or mental illness, as the case may be. Alternative explanations of mental illness have been established as a dominant theme in this study. However, alternative practices have failed to provide enough categories that can enhance the development of a framework for contextualising madness in social situations. For example, in the movies, reference to magical objects or spells for explaining emergence of mental illness have been pinned

down through visual effects. Are these magical charges seen in real life instances where magic cause madness; are there specific magic wands that make this happen; or are there specific kind of people who can make people become mad? Answer to the last question has been provided in the narratives where reference to magic has always been associated with an *Ifa* priest, Christian Cleric/Pastor or an Islamic Cleric.

Also, in the movies, alternative treatment centres often treat the mentally ill as animal: left to sleep in the open; chained like an animal; and fed like an animal. This is not so different from why historians like Foucault (1965) spoke against the practice of state mental asylums in western nations. If these are the ways the alternative modes attend to treating the mentally ill and are still dominant, the preference for this form of practice over psychiatry may mean that psychiatric practise in Nigeria has not positioned itself as an option that provides better services; restrain from practices that dehumanise the mentally ill; and provide better prognosis. If psychiatry cannot provide all these, then social members are likely to choose a system or mode that attracts fewer stigmas, thus suggesting that power relations in psychiatric or

alternative modes of conceiving mental illness rely on the mode that social members find less stigmatising.

8.7.2 Science and Madness in Movies

Disparity in alternative and science-based causal and treatment themes has been reported in other studies too (Aina 2004; Ayorinde *et al.* 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011a). In the movies analysed, scientific explanations of ways certain symptoms best describe specific types of mental illnesses were not found. In fact, in all the movies, no diagnosis was made from the scientific point of view, except in the movie *Tears of Madness* where attribution was made to ‘shock’ as a diagnosis for mental illness in the mentally ill character. In the movie *Obiripo*, total remission of symptoms of mental illness that emerged from magic was attributed to a combination of science and alternative treatment modality, a theme similar to the proposition made for ‘spiritual psychiatry’ (Wig 1999; Fernando 2007): the integration of psychiatry and spiritual beliefs in causal and treatment explanations of mental illness.

Reasons for low presence of psychiatry in the list of treatment options that may lead to cure of mental illness are uncertain. The absence of convincing scientific explanations on societal issues may allow strands of alternative information about causes and treatments of mental illness to permeate through various media or culture (Lavis 2005). What is evident from the analysis is that medical or science-based health systems are rarely adopted in the representation of mental health themes in movies produced in Nigeria (Aina 2004; Atilola and Olayiwola 2011). The underlying consequence of this may not be far-fetched. If the media is an important source of information on social issues for certain segment of audiences, persistence in portrayals of mental illness from alternative point of view may create doubts in the existence or efficacy of science based treatment modes.

In this analysis, representations of psychiatry showed a misdiagnosis of sufferers and the inefficiency of psychiatry (*Tears of Madness, Obiripo, Ire Aje, and Mad Couple*). Minimal reference to psychiatry in the movies is indicative of a social practice that may not be aware of the existence of psychiatry. Subtle reference to psychiatry in some of the movies may have refuted this claim. Also, social representatives whose experience with psychiatry is not shared with other social

members may also account for the less prominence of psychiatry. In this instance, stigma associated with mental health care spaces in Nigeria provides an example. The fear of being described as 'yaba' or 'aro', names of places that have become coinage for describing the mentally ill in Nigeria, may discourage people from making their experiences with psychiatry public, thus contributing to the less prominence of psychiatry. In the event where psychiatry has failed to provide mental health care services that has proven to be helpful, psychiatry will be less absorbed by Nigerians. Finally, the social beliefs of individuals or social groups that produce movies are indicative of the dominance of alternative views in mental illness. The dominance of alternative mental health views suggests that a large number of movie producers, directors or writers may have either some belief in magical explanations of mental illness, over psychiatry, or are interested in promoting it as a dramatization of the idea. If these categories of producers remain powerful members of the social structure that represents images of mental illness, alternative themes will persist as the dominant theme over psychiatry in movie representations of mental health issues just as the result of this study suggests.

8.7.3 Mental Frames of Mental Illness in the Movies

Results from analysis showed that there are many important themes in the movies that may affect people's attitude towards mental illness. It is crucial to note that the depiction of mental illness in movies plays a significant role in the overall structure of the narrative. To further understand the purpose of the categorisation of emergent themes in the movies, all the themes have been described under negative and positive representations of mental health issues. The constitution of positive presentation in the movies included depictions that are assumed may reduce the stereotype or stigma people have towards mental health. Positive or negative representations have not been adjudged from the psychiatric point of view only. However, specific categories with themes that naturally evoke negative or positive interpretations of mental disorder have aided the description of some themes as negative or positive. Negative portrayals are depictions that may allow negative perceptions and beliefs about mental illness to thrive.

Before the result from movie analysis is further delineated into positive and negative themes, representation of mental health issues in the movies showed that magic or spiritualism

is a prominent concept under alternative mental health modes. The attribution of causes of mental disorder to magical manipulations or spells from a possessor of magical or mystical powers is a recurring theme in the analysis of movies produced in Nigeria (Aina 2004; Atilola and Olayiwola 2011). Psychiatry or science-based mental health is a rare concept in the depictions of mental health issues in the movies. Full recovery or remission of symptoms of mental illness in some characters was also attributed largely to alternative treatment interventions. Even in situations where prior consultation was made to science-based treatments modes, alternative treatment options enjoyed greater reference to recovery than science. The discrepancy in the way alternative and science based mental health was adopted in narratives may have serious implications for psychiatry in Nigeria.

The difference in depictions of mental health themes in movies made in the Yoruba and English language genre was not significant. Interpretations of causes and treatments of mental illness in the narratives shared a lot of similarity. However, stereotypic portrayals such as attributing madness to violence were found to be more in the Yoruba language genre movies than the English language genres. Another

important stigmatic representation that was found in the structures of the narratives was in the depiction of mentally ill characters as victims more than as heroes, despite the dominance of mentally ill characters in significant role parts (lead and supporting roles).

In addition, the way movies present images of symptoms that imply the presence of mental illness of some sort is an interesting part of the information this analysis revealed. A few studies have analysed the content of movies made in Nigeria for themes of mental health (Aina 2004; Atilola and Olayiwola 2011a; Armiyau 2015). From the analysis, mentally ill characters in the movies were primarily portrayed as over elated, aggressive, vagrant, hallucinatory, delusional, hoarders, unkempt, hysteric and regressed in behaviour. In Armiyau's (2015) analysis of people's perception of what constitutes symptoms of mental illness among Northern Nigerians, images of mental health showed that the most common symptoms of mental illness as it is known to the people are aggression, loquaciousness, eccentric behaviour and wandering. There is a similarity in the perceptions of symptoms of mental illness that reside in social practices and media representations. The layman may be unable to use clear terms such as hallucination or delusion to adequately

grasp the images they see, but the term eccentric behaviour encapsulates all bizarre behaviour that they think best describe what they know of symptoms of mental illness.

Referencing madness to high intellectualism or genius was observed in one of the movies (*Mad Couple*). This is a theme in the movie that was difficult to categorise as reference was also made to causes from magic. However, reference to the character as becoming mentally ill from studying very hard as a medical student may have a link with the perception that madness has a correlation with high intelligence. The association of mental illness with genius has a long history in Western thought (Porter 2002; Lavis 2005) and in African social construct of causes of mental disorder in persons assumed to be highly intelligent. Though, Lavis (2005) referenced genius in mental illness to creativity in art, situating insanity with stressing the brain reflect an existing concept of mental disorder in the Nigerian context.

8.7.4 Positive Representations in Narratives

Positive mental health themes in this analysis came from the same categories and sub categories that negative themes

emerged from. Positive representations were reflected in framings of full recovery; and partial recovery (i.e. complete remission of symptoms with risk of relapse or partial remission with the risk of relapse) from episodes of mental illness. Results from this study revealed that higher attribution was made to full recovery from alternative mental health care intervention (30.77%), while attribution of recovery from scientific based intervention (23.10%) followed closely in representation. In a study carried out to examine trends of reporting mental health issues in two Scottish newspapers, recovery optimism fell under positive representation, while recovery pessimism was regarded as negative (Knifton and Quinn 2008) representation of mental health issues in the media. In this study, Knifton and Quinn's views on recovery have been adopted in categorising different levels of recovery - as suggested in DSM-IV (1994) – into positive and negative themes.

Film messages that make full or partial recovery from mental illness salient in the structuring of narratives may influence positive perceptions of mental disorder. However, there exists the verisimilitude in perceptions of recovery from alternative or science-based treatment options of mental illness. What is observable in social practice in Nigeria is that psychiatry and

alternative modes provide different perspectives of recovery. Users of alternative modes, even as suggested in the movies, believe mental illness that emerges from magical means will require a corresponding magical or supernatural mode to combat. This may explain why themes of full recovery from magical intervention in the movies are dominant. In cases where symptoms of mental illness persist after psychiatric interventions, movie producers are either expressing their perception or experience of how psychiatry works; or are reflecting social perception of how psychiatry works. According to Thornicroft *et al.* (2007), people's perception of psychiatric drugs is that they cause more side effects than cardiac drugs, and since the contact a layman has with the mentally ill persons is limited, the media becomes a major source of information for confirming the truism in the possibility of recovery after episodes of mental illness. Although, reference to full recovery from adopting science-based modes followed alternative mode closely in rate of representation, representations that suggest alternative modes bring healing to the mentally ill faster in the instance where psychiatry has been slow to enhance recovery – in movies such as *Obiripo*, *Ire Aje*, *Mad Couple*, *Elulu*) – may overshadow the viability in the view that science based modes offer full recovery solutions.

Another positive representation of mental health issues in the movies was observed in the absence of ascribing violence from other characters towards the mentally ill. This was evident in the absence of themes such as physical assault, name calling, economic or social depravation and harm to self as themes of negative import that can be found in many portrayals of mental illness. Nine out of ten movies analysed for this research did not ascribe violence from the mentally ill to others (either in provoked or non-provoked situations) as a characteristic of mental illness. Positive perceptions of portrayals are deducible also from themes suggesting that the mentally ill are not easy access for economic and sexual exploitation (84.6%, n= 11). The adoption of persuasion as a tool to get mentally ill characters to behave in desired ways indicate positivism as against other portrayals that suggest force or coercion in obtaining compliance from the mentally ill. The positivism in adopting persuasion in place of coercion in dealing with the mentally ill may reduce the impact of representations that suggest the mentally ill are weak. The adoption of persuasion to get mentally ill characters to engage in desired action run contrary to representations of mental health that suggest the use of force or restraint - such as chains and ropes - for the same purpose.

The indication that magic can be used for the purpose of helping or bestowing favours on others through mental illness is an interesting theme that emerged in some of the narratives (*Ore Meta Were Kan*). The positive angle to this representation is in the choice of ascribing goodness to the mentally ill amidst situations where mentally ill characters have been shown to use magic as a means to harm others. This may nurture the perception that the mentally ill aren't as 'bad' as we know from fictional materials studied particularly in western regions (Philo *et al.* 1996; Rose 1998).

Other positive portrayals contained in the movies analysed in this study, are depictions of calm and subtle display of mental illness (23.1%, n= 3). Indication that the mentally ill can indeed show willingness to get better by cooperating with efforts made at seeking recovery points to the view that the mentally ill are capable of making decisions that pertain to their health. Thus, these depictions indicate that mentally ill characters are capable of making decisions by societal standards.

The feelings of pity towards the mentally ill and actions of acceptance and compassion by other characters towards the

mentally ill are indicative of positive themes as against negative ones such as reproach and disgust. In this study, pity has been conceptualised as a cognitive response that other characters have towards the mentally ill, which may reduce the level of distance or stigma towards the mentally ill. However, in disability studies, representations of disabled character in films as 'people who are powerless and pathetic in order to evoke fear, sympathy or pity' have been referred to as stereotypic constructions of the disabled people (Oliver and Barnes 1998, p.65). In some studies, mental illness is incorporated into disability studies and thus, reference to pity as a positive theme may be considered demeaning for the mentally ill. Also, it is agreeable that conceptions of pity may be negative in some aspect where it evokes perception that the mentally ill are ill-fated, in a regrettable position or in a situation of misfortune. However, it can be argued that pity can be deployed as a positive theme of mental illness in perceptions of pity to imply compassion, an important ingredient that foster positive social interaction and existence, which makes it possible also for the society and policy makers to look at mental illness or disability plainly from the point of view of the mentally ill or disabled.

8.7.5 **Negative Representations in Narratives**

Negative representations of mental health issues in the movies are themes that reflect negative perceptions of mental illness. Firstly, negative portrayals in the movies were observed in choices made by producers: present the mentally ill as suffering from persistent disorder; progressive deterioration; and to refuse to indicate any form of recovery (recovery status). Negative motifs were also implied when the mentally ill is not shown to recover fully or partially from either alternative or scientific based treatment options. This is because notions such as this may encourage the belief that mental illness is not curable or that the possibility of recovering from episodes of mental disorder is negligible. The import of categorising recovery status in narratives on mental health is better appreciated in the movie analysis report that showed that majority of the movies did not indicate or suggest possibility of recovery from either exposure to scientific 92.35% (n = 12) or alternative 53.85% (n = 7) interventions.

Magic is also an important theme in the way mental illness is described negatively in movies. One of such explanations is how magic can be used to cause harm on others. In the movie

Obiripo, the cause effect explanation on how the mentally ill character (*Enitan's* mother) became ill was referenced to the consumption of a 'poisoned meal'. The 'poison' in the movie is not the type that causes death or stomach upset but that, which can magically cause mental illness in whoever consumes it. In an interesting repetition but with a little twist, the second mentally ill character (*Enitan's* mother's co-wife) in the same movie became mentally ill as a consequence of inflicting mental illness on the first mentally ill character (*Enitan's* mother). Thus, the underlining theme here suggested putting magic to negative use. The movies, *Elulu 1* and *Elulu 2*, also referred to magic as a means to 'inflict' mental illness on others. The negative consequence of adopting magic as a means of explaining mental illness can be found in the perception that the mentally ill is to be blamed for the emergence of mental illness. Associating mental illness to repercussions or consequence of attempting or engaging in evil acts has also been reported in the study by Atilola and Olayiwola (2011a).

Blameworthiness may be a recurring theme in media representations of mental illness across cultures (Knifton and Quinn 2008). A similarity in the operationalisation of blameworthiness as a concept in Western (Knifton and Quinn

2008) and African (Gureje *et al.* 2005) contexts appear in attributions of emergence of mental illness to substance abuse (Rüsch *et al.* 2005) or careless living. However, an emerging aspect of blameworthiness may include attributing retribution or consequence of magically harming others as a possible cause of mental illness. The act of blaming the mentally ill for the emergence of mental disorder is a theme that featured in three of movies (*Ore Meta Were Kan*, *Egwonga* and *Obiripo*). The attribution of magic gone wrong as reasons why people become mentally ill presents a negative interpretation of causes of mental illness. The correctness of these positions in social reality may be relative but, media framings that suggest mentally ill characters deserve what they got, mental disorder, are aspects of media representations that reflect negativism in portrayals of mental health issues.

Crucial to categorising certain depictions of mental illness as negative is the conceptualisation of the mentally ill as victims. Knifton and Quinn (2008) reported that representations of the mentally ill as victims featured as the fourth most popular portrayal in the media (newspaper publication in Scotland). In this study, victim is a theme that encapsulates all depictions that place the mentally ill as

recipients of various forms of violence, stereotype, prejudice and discrimination (Corrigan and Watson 2002). An addition to the negative representation of mentally ill characters in the structuring of narratives was the characterisation of the mentally ill as villains. The movies, *Obiripo* and *Elulu 2* portrayed scenes that showed the mentally ill as agent of equilibrium disruption – the doer of actions that causes harm to important characters in the narratives.

8.7.6 Mental Illness and Violence

Themes that suggested that the mentally ill are violent or recipient of violent actions in the form of physical assault, name calling, economic/social deprivation and sexual abuse reflect negative themes. Movie representation of the mentally ill as suicidal and prone to self-harm in this study was low (7.7%, n= 1). The movie (*Egwonga 2*) represented the mentally ill as suicidal and prone to self-harm. This single representation gives insight to the negative interpretations of mental illness in the media. Investigation into themes of suicide ideation or harm to self in media products have been carried out by Crepaz–Keay (1996). Atilola and Olayiwola (2011) also reported suicide ideation as part of the symptoms of mental illness presented as identifiable themes in Yoruba

language films. The ascription of suicide ideation to negative representation of mental illness in this study is not in the manifestations of symptoms of mental illness in severe cases of some diagnosable mental illness (DSM – IV) but, in the potential social distance such stereotypic portrayal may encourage (Morris 2006).

However, relating mental illness to suicidal ideation may imply that the producers do not necessarily associate mental illness to suicide as a relevant symptom of mental illness. It may also mean that the singular reference to suicide as a manifestation of mental disorder suggest that there exists a relationship between self-harm or suicide ideation and mental illness. The essence of this study is not to establish the literal truth in the possible link between mental illness and suicidal affects from sociological and scientific postulations, but rather the analysis employed was to highlight themes of mental illness that may be found in movies and their implication for understanding mental health images in the Nigerian context.

Stereotypical association of violence with mental illness is high within the medium of film (Morris 2006). In this study,

the presence of themes of violence towards the mentally ill in the forms of physical assault, name calling, economic/social depravation and sexual abuse reflect negativism in the way movies frame mental health issues. In studies carried out in the Western culture: Scotland (Knifton and Quinn 2008); United Kingdom as a whole (Philo *et al.* 1996); and the United States of America (Wahl 1992), violence and danger appear has the most common and popular representation of mental illness in the media (Rose 1998). As reported by Atilola and Olayiwola (2011), unprovoked aggression was the fourth most common symptoms of mental illness emphasized in Yoruba language genre movies. However, in this study, themes of violence as a feature of the mentally ill were not as prominent as it has been reported in previous studies. This is evident in the fact that murderous tendencies and sexual abuse as forms of violence mentally ill characters engage in were not implied in the movies.

In the same vein, mentally ill characters in the movies engaged in physical assault of others in provoked (38.5%, n= 5) and unprovoked (38.5%, n = 5) situations. An explanation for this is that you do not have to be portrayed as mentally ill to as a matter of reaction engage in physical assault in provoked situations. However, references made to actions of

aggression by the mentally ill in unprovoked situations represent the form of violence that is attributed to mental illness in common narratives. The notion of engaging in aggressive behaviour in unprovoked situations is similar to ‘unpredictability’ of the mentally ill that has been reported in other studies (Philo *et al.* 1996; Knifton and Quinn 2008).

Negative themes in the movies also included framing the mentally ill as capable of engaging in actions of physical and verbal assaults due to provocation. Representations of unprovoked violence by the mentally ill are similar to that of provoked reactions to violence from other characters in the narratives. Thus, the presentation of the mentally ill as capable of inflicting verbal, sexual and physical injury on others in unprovoked situations did not feature in the movies. This study endeavoured to examine how the mentally ill is portrayed, not only as doers of violent actions but, as victims of violence. It was observed that the level of unprovoked violence by the mentally ill towards others (38.4%, n= 5) in comparison with violence from others towards the mentally ill (30.7%, n= 4) appeared negligible.

However, the importance of highlighting themes that suggest that mentally ill characters are recipients of violence cannot be evaded. A targeted recipient of physical assault is considered weak. If this perception of weakness is extended to economic or social deprivation of the mentally ill, then views that the mentally ill are unable to hold responsible positions or take care of themselves, will persist (Knifton and Quinn 2008).

Sexual abuse as a form of violence carried out on the mentally ill is a negative theme that presents the mentally ill as vulnerable. Other studies that may have investigated the portrayal of the mentally disordered as object of sexual abuse were not found. This portend that the identification of sexual abuse of the mentally ill in movie representation of mental health issues is a newer contribution to the corpus of studies that have investigated movie representation of mental health issues in Nigeria. Sexual abuse of the mentally ill character is a theme that occurred in the movie *Ire Aje*. In this movie, the depiction that magic or sedatives put in meals can be used to enforce cooperation from mentally ill characters in order to sexually take advantage of them for personal benefit may have multifarious meanings. One such meaning is the perception that the mentally ill create little or no difficulty in

situations where manipulations for selfish interest are intended (*Aso Were* and *Ire Aje*). Another possible meaning that could be evoked is attribution of weakness to the mentally ill.

Also, the use of ropes and chains to restrain the mentally ill is a negative theme that suggests that the mentally disordered are better controlled in such ways. The use of restraint as depicted in the movies cannot be said to represent how people will behave towards persons suffering from mental illness in reality. However, the depiction is suggestive of methods that could be used to force the mentally ill to behave in desired manner. Depictions such as these are suggestive of discrimination towards the mentally ill that may affect many aspect of mental health such as help seeking, disclosure of mental health status, or suggesting mental health services for friends or families.

8.7.7 Themes of Stigma in the Movies

Stigma encapsulates cognitive and affective responses to different images of mental health. According to Corrigan and Watson (2002), stigma can either be self or public stigma. For

stigma in mental health to be understood, prejudice, stereotype and discrimination must be observed in social interaction with mental health issues (Corrigan and Watson 2002). It is against this backdrop that images from the movies analysed was categorised as prejudicial, stereotypic or discriminatory. As argued by Corrigan and Watson (2002), the mentally ill as dangerous and violent individuals is a stereotypic theme that is associated significantly with the perception of mental illness in western countries, while potential for stigma in African context is in mental illnesses that alternative treatments modes have failed to cure. The result from this analysis showed that poor attribution of success to psychiatry; negligible references to psychiatry; and non-existing science-based diagnosis of mental illness in movies are important factors in perceptions that may allow stigma of psychiatric modes to thrive.

In the movies analysed, it was observed that female gender were referred to as suffering more from mental illness than the male counterpart. The truism in this representation may not be ascertained in Nigeria, however, a study on gender and mental illness in the Western part of the world argued that the predominance of women as sufferers of mental illness is in specific disorders and not in general mental disorders

(Eriksen and Victoria 2008). More men have been argued to suffer from mental illness associated with drug abuse and sexual abuse, while women were found to suffer more from mental disorders that are associated with mood and anxiety (*Ibid*). The portrayal of women as more vulnerable to mental disorder is a theme that may stereotypically affect the way women are perceived in the society. It will require further research to confirm if women are more predisposed to mental ill-health than men in Nigeria. As a mark of difference, causes of mental illness in female characters did not correspond with notions associated with moods and anxiety in this study, except in the movie *Tears of Madness*, where the mentally ill character became mad from the sudden death of her child. In this study, magical/spiritual explanations were largely ascribed to as sources of mental disorder in female characters.

Attributions to danger emerged from perceptions of violence that were ascribed to the mentally ill. However, in movies produced in Nigeria, themes of violence are not as pronounced as it has been reported in Western media (Philo *et al.* 1996; Wahl 2003; Knifton and Quinn 2008). Physical aggression from the mentally ill emerged as a theme in the movies, however, none of the mentally ill character was

presented as committing murder or portrayed as intending to. Behavioural reproaches towards the mentally ill and cognitive feeling of disgust are themes that emerged largely in the movies. Representations of mental illness that evoke feelings of disgust towards the mentally ill were tagged stereotypic in this study. Thus, other emergent themes categorised in this study as negative representations of mental illness include thoughts of anger, feelings of disgust and reproach towards the mentally ill. Reproach (53.85%, n = 7), anger (15.4%, n = 2) and disgust (15.4%, n = 2) were discriminatory themes in the analysed narratives. Constructing the mentally ill as fearful agents of aggression (46.2%, n = 6) or violence in narratives may be an extension of the perception of the mentally ill as violent, dangerous or unpredictable (Henderson 1996; Knifton and Quinn 2008). Themes such as fear in other characters towards the mentally ill due to unpredictable actions that are assumed may come from the mentally ill, are expressions in movies that suggest prejudice in mental health. However, as argued in other studies, been mad and bad are two mutually exclusive concepts that have eluded representations of mental illness in the broad media (Cross 2014). Violence as a theme in the media has often times been looked at from the perspective of the 'mad' inflicting injury on the 'sane'. In this analysis, it was observed

that violence can be evaluated from the perspective of the mentally ill as a receiver of violence and as a doer of violence.

In analysing narrative elements in the movies, it was observed that a large fraction of the movies referred to the mentally ill as victims (80%, n= 8). Portrayals of the mentally ill as victims cut across different conceptions of the mentally ill as weak and vulnerable. One of the many possible interpretations of weakness in the mentally ill can be found in perceptions that suggest that the mentally ill cannot take up jobs as sufferers. None of the mentally ill characters were shown as economically independent or capable of caring for themselves. Expressions of vulnerability were found in depictions of the mentally ill character as an easy object for sexual exploitation and magical manipulations. Further investigation is required to enhance an empirical comparison between the objectification of the mentally ill in the media and actual attitude that reside in social settings. However, depiction of the mentally ill as hero (10%, n= 1) and villain (20%, n= 2) featured in the narratives. The overwhelming attribution to weakness and vulnerability in the movies analysed suggest themes of stigma that are rarely found in the analysis of narratives with mental health themes.

CHAPTER NINE

INTERVIEW ANALYSIS

9.0 RESEARCH TECHNIQUE USING DATA FROM INTERVIEWS

Interview of six respondents formed the second data gathering technique that this research adopted. Key important technique (Tremblay 1982 in Jankowicz 2013), which involved questioning people with specialized knowledge about mental health, was employed in selecting producers and psychiatric professionals as respondents. Three professionals from the mental health sector and three professionals in movie production were selected as respondents. In the category of movie producers, selection was based on the researcher's observation of trends and events in the Nigerian movie environment over the years. In other words, movie content producers that have made a difference in movie production were selected. Some of the respondents were producers of some of the most locally and internationally recognized and marketed movies; producers of most nationally acknowledged movies; and seasoned and legendary producers in the field of movie-making in Nigeria.

Interviewing producers became necessary due to the upsurge of movie making in Nigeria; perceived influence of movies; and influence movie makers are assumed to have in the formation of opinion and attitude towards various social issues. The level of influence may be apparent in the attitude and behaviour of social members and in the perception of social reality (Gamson *et al.* 1992). Semi structured questions were developed in order to identify themes that are consistent with the set objectives of this research. Questions asked from producers revolved around some of the stories they write and their sources for research - as this is perceived to be as crucial as what is contained in the narratives. This study focused on understanding how and why producers represent mental health issues the way they do.

On the other hand, mental health care professionals were sought from Neuro-Psychiatric hospital, Yaba in Lagos – the most populous city in Nigeria. Two of the selected psychiatric professionals were at the apex of administration in the Psychology Department of the hospital at the time of the interview. The last of the three psychiatric professionals was a highly-positioned Consultant Psychiatrist in the same hospital. The need to examine if representations of mental health in movies are antecedent to perceptions held about

mental health formed the rationale for analysing views of psychiatric professionals on media representation of mental health issues in Nigeria.

9.1 ANALYSING TRANSCRIBED INTERVIEWS

The second phase of data gathering in this research involved interviews with key professional movie producers/directors and professional mental health care providers in Nigeria. The movie producers/directors were fluent speakers of English and Yoruba languages; and are prominent in the production of movies in both languages. Movies of these producers are aesthetically acclaimed. All the producers emerged from the South-Western region of Nigeria. Besides the prominence of the movies, the movie producers/directors have produced at least one film with mental health themes. One of the movies analysed in this work was produced by one of the interviewed respondents. However, movies produced by the other two producers were not analysed simply because the movies were not produced in years 2013 or 2014.

The interviews were conducted using the semi structured format. Appointments were fixed with individual respondents

and the interviews were conducted in the comfort zones (like offices) of individual respondents. The purpose of the research was clearly explained to all respondents and their consents were given formally. The sample for each category, producers and psychiatric professionals, was drawn purposively using expert sampling. Here, the researcher looked for individuals who have particular expertise and are more able to advance the researcher's interests (Given 2008). Each respondent was chosen on the basis of the specialized knowledge they could bring to this enquiry. The concept of selectively choosing respondents from both the movie production and mental health care professions was driven by Jorm's (2000) argument that professionals have expert knowledge.

9.2 METHOD OF TRANSCRIPTION

The interview was recorded using a voice recorder and the content was transcribed for further analysis. The transcribed interview of this work was denaturalized: stutters pauses, non-verbal cues, and involuntary vocalization were removed during the course of transcription. This is to ensure that the intended messages in the respondents' responses were not lost in the literal noise 'naturalized' transcription may

present. Interest in the accuracy of the transcribed data concerns the substance of the interview: meanings and perceptions created and shared during conversations (Oliver *et al.* 2005).

In adopting a connected narrative approach to analysing the transcribed interviews, an attempt was made at presenting various viewpoints using categories that reflect major perspectives of mental health issues. From the data, recurring themes were identified and categorised to enable the organisation of respondents' submissions. Though, questions posed to the respondents were semi structured, the questions were largely tailored in line with the established objectives of the study. Representative quotations that identified speakers by role were used in presenting a discourse around themes from transcribed data. In the transcribed data, specific words were adopted as themes for identifying and allocating word clusters as quotes for representing categorised themes (Folkestad 2008).

9.3 EMERGING THEMES AND CATEGORIES FROM INTERVIEW DATA

The focus of this section of analysis is to search for answers to some of the research questions of this study. The first question is to enquire into the extent to which the media, particularly fictional narratives convey mental health issues in Nigeria. The motive in this analysis is to identify perceptions of the professionals on what counts as knowledge of mental health: the extent at which information on mental health is perceived to be available or unavailable. The second research question includes investigating perceptions of media representation of mental health among professional producers and mental health care providers.

9.3.1 Psychologists and Psychiatric Professionals: the themes have been segmented into categories for easy interpretation. In accordance with the Data Protection Act, which requires covert representation of respondents' identity, *Psy One*, *Psy Two* and *Psy Three* were employed as titles for representing the views of interviewed professional mental health care providers. *Psy One* and *Psy Two* were specialists in psychology at Yaba Neuro-Psychiatric Hospital, and *Psy*

Three is a consultant neuro-psychiatrist from the same hospital in Nigeria.

9.3.2 Media Producers: the three movie producers were identified using *Pro One*, *Pro Two* and *Pro Three* as titles in order to protect respondents' right to protection of identity. All three interviewed producers are experts in producing movies and are overtly popular among viewers from the South-Western part of Nigeria. The three producers hail from the South-West; and produce movies in English and Yoruba languages. The transcribed interview data were reduced to major categories and sub categories using unitization and categorisation method. The major categories that emerged from identifying mental health themes in the body of the transcript were:

1. Availability and access to information on mental health issues;
2. Representation of mental health issues in the media;
3. Attitudes and behaviour towards mental illness
4. Stigmatisation in representations of mental health.

9.4 DEVELOPING A NARRATIVE

The import of assembling the thoughts and opinion of mental health professionals and producers of movie content in Nigeria is embedded in the objectives and contribution of this study to knowledge. Responses from the interviewees presented patterns that reflect perceptions of mental health issues among media and mental health care professionals. Quotes have been used to establish the respondents' thoughts on issues, using specific themes to ascribe certain statements by respondents to developed categories and sub categories. In most cases, more than one statement with themes of interest were extracted from transcribed interview of individual respondents, but the statement that appears to be most relevant to the highlighted theme(s), categories and sub categories was used as quotes to represent the thoughts of each individual respondent. In situations where attribution is not made to a respondent's statement in a particular sub category, it simply implies that the response from such respondent do not fall under the criteria for selection using clustered themes.

9.4.1 Availability and Access to Information on Mental Health

In order to understand the type of information on mental health that is available and accessible to movie producer/directors and mental health care providers, some themes and subcategories were developed to achieve this. The themes developed to access the form and level of information on mental health were “knowledge”, “Information”, “awareness” and “education”. Subsequently, three subcategories further emerged from the highlighted themes. The sub categories are:

- 1) Unavailability of information
- 2) Knowledge of mental illness
- 3) Misinformation on mental illness and
- 4) Available Information on mental illness.

9.4.2 Unavailability of Information

Examining available information on mental illness was an attempt made at exploring the cognitive perception of mental illness that is explicitly and implicitly expressed in comments of respondents. Controversy seem to trail the concept of knowledge among individuals who have been trained

scientifically to diagnose mental illness from globally acceptable diagnostic manual (Porter 2002) such as the various versions of DSM – diagnostic and statistical manual; and individuals whose source of information about mental health is strictly cultural, some of which are acquired through observation of social practices, media representations and social interactions. In other words, differences exist between public belief and professional understanding of mental health (Jorm 2000). According to Brodie *et al.* (2001), a lot of Americans get information about their health largely from health care providers and the media. Against the backdrop of cultivation theory, Brodie *et al.* (2001) argued that health information provided in the media could affect the knowledge people have about health related issues and perceptions of mental health issues (Vogel *et al.* 2008).

Since the emphasis here is not on health-related matters generally, information on mental health specifically in Nigeria (mhLAP 2012) evokes alternative mental health interpretations (spiritual, magic and supernatural) in causal explanations of mental illness. The mental health leadership and advocacy report (mhLAP 2012) related negativism to perceptions of alternative mental health and dialectically

related positive representation of mental health to psychiatry. According to Gureje *et al.* (2005), knowledge about mental health in the Nigerian context is poor. The use of the adjective ‘poor’ was to describe the knowledge people have about mental health that suggest that mental illness could be treated outside of a mental health facility or other health care facilities.

In this study, experts in the profession of treating mental illness are of the opinion that most people are unaware of the potency and efficacy of orthodox mental health care. In response to questions inquiring into respondents’ perception of information availability on mental health issues, a recurring position is that there is not enough information; and access to basic information about bio-medical mental health care. Psy One stated that:

“We don’t have enough information about orthodox health when it comes to mental health. We don’t have enough. ... quite a lot of people out there have most of these psychological conditions that we see that they complain of but one way or the other they don’t know what they do. They just go around with the condition and with the illness. So they don’t seek help because they don’t know what is happening to them, including things as obvious as seizure disorders. Some will just believe that it is another thing entirely. That it is an attack from the gods or something like that. Depression is the worst culprit.

Most people with depressive symptoms will treat entirely other things totally; they will treat typhoid fever, they will treat malaria. They will treat all sorts of things. They will treat so many things that are symptoms of depression, but it is actually difficult for them to seek help for the condition.”

By adopting ideological theory for analysing the belief system of the psychiatrist quoted above, the model-mental representation of people’s experience of social practice (van Dijk 1995a) in the above comment suggests that available information on mental health is not enough. In the quote above, the use of ‘depression’ or ‘seizure disorder’ as terms to describe mental disorder implied the specificity of science as a body of knowledge or information about mental health: It establishes a dichotomy between science and an ‘other’. This interpretation situates psychiatry in the dominant position for analysing availability of information on mental health; and to show how much is known of symptoms of mental illness as identifiable signs. There are two major ‘others’ that the positions of the respondent in the quote above suggest. The phrase, “...Some will just believe that it is another thing entirely. That it is an attack from the gods or something like that....” identifies the existence of belief in something other than science that is not worth emphasizing on; and to some other form of belief in causes of mental health that is not

relevant to psychiatry (van Dijk 1995a). This can be found in the second category of the 'other' in the quote below:

“Most people with depressive symptoms will treat entirely other things totally; they will treat typhoid fever, they will treat malaria. They will treat all sorts of things. They will treat so many things that are symptoms of depression, but it is actually difficult for them to seek help for the condition.” (Psy One)

The statement 'difficult for them to seek help' evoke multiple interpretations on the impact absence of knowledge on symptoms of mental illness from scientific views can have on finding appropriate treatment options. Difficulty in this sense may imply the inability to identify major symptoms of mental illness, which is different from other health problems that people visit hospitals for.

9.4.3 Knowledge of Mental Illness

The source of information about mental health is as crucial as the attitude that informs people's behaviour towards incidences of mental illness. Sources of information about mental health include the television (Vogel *et al.* 2008) that may constitute one of the most significant source of knowledge about mental illness (Ednay 2004); newspaper

(Knifton and Quinn 2008); and cultural beliefs (Aina 2004). As Berger and Luckmann (1966) argued, knowledge is developed, transmitted and maintained in social situations that body of knowledge pass through to constitute social representations of reality. Sometimes, knowledge is acquired from unidentifiable sources. According to Chen and Mak (2008), culture is not only known for shaping attitudes towards seeking help for mental illness, it also aids in the documentation of lay beliefs about mental health. The sociocultural knowledge shared by members of a social group forms the belief and opinions that are formed into social attitude (van Dijk 1995a). Comments extracted from producers and mental health professionals suggest that science-based information about mental health do not constitute social knowledge that are acquired culturally to form popular social practice. Berger and Luckmann (1966, p.208) argued that the 'role of knowledge in a dialectic of individual and society, of personal identity and social structure, provide a crucial complementary perspective for all area of sociology'. Information based on the medicalisation of psychiatry is confined to members of social groups that have the opportunity to interact with science-based mental health care. As specified by the *Pro One* respondent in the quote below:

Pro One “ Hmm apart from, I really don’t have any source of information but what I know is that when the script came to life, I had to visit Yaba (Yaba Neuro-Psychiatric Hospital, Lagos Nigeria) to probably know some other thing I have not been told in my life”.

Visiting mental health care institution formed the basis of acquiring information about psychiatry that would hitherto have remained unknown. Summarily, availability of information about science based mental health, from the point of view of respondents, was considered inadequate. People are seen as poorly informed of the causes and treatments of mental illness from the perspective of science. The reasons for the poor availability of information on science-based mental health were not explicitly expressed.

9.4.4 Misinformation on Mental Illness

Misinformation is operationalised in this study as the existence of mixed interpretations or meanings of issues related to mental illness. Reports from other studies (Philo *et al.* 1996; Knifton and Quinn 2008; Quinteros Johnson and Riles 2016) on media analysis of mental health issues suggest that public perceptions of mental illness are obscured by misinformation, misconception and misrepresentation. The

motive here is to examine misleading or misguiding information about mental illness. Misinformation is conceptualised as inaccurate information on mental health based on respondents' judgement of what constitutes proper information or misinformation. As argued earlier, the mental health care professionals, largely influenced by the normative medicalisation of madness, analysed the quality of information about mental health based on expectations of what should constitute proper information on mental health.

"Some will just believe that it is another thing entirely. That it is an attack from the gods or something like that".
(Psy One)

Here, the science based mental health care professionals appear to have an idea of what constitutes misinformation in the way mental illness is conceived by the public. Reference to spiritualism and magical affect as explanations of causes and treatments of mental illness represent perceptions that respondents' associate misconception with. From the responses of science based mental health professionals:

Psy Two said, "Mental illness is still shrouded in a lot of mystery in this part of the world. People still feel this way except for people who are educated, (though not all the time) or people who have someone who is working at the hospital. Your level of education doesn't necessarily affect the perception about mental illness."

What has been observed shows that social beliefs in causes of mental illness that do not conform with science-based explanations of causes of mental disorders are often referred to as ‘shrouded in mystery’ or misconceived. Using specific themes for data reduction, responses from producers did not suggest representations of misinformation in their perception of information on mental health. This result is very important as it opens discussion on knowledge of mental health in many directions. Ideologically, negativism is observed in the way dominant groups (medical scientist) struggle to establish their perception of mental health as the truth, while *other* perceptions constitute misrepresentations of the truth. Thus, representations that do not reflect mental health in ways that are acceptable to psychiatric professional practice are considered a move towards misinformation. Reference to *“People still feel this way except for people who are educated, (though not all the time) or people who have someone who is working at the hospital”* (Psy Two) analytically reveals a supposed difference between people who hold perceptions of mental health from scientific and alternative perspectives. The difference suggested here emanates from the assumption that acquisition of western education – which involves scientific explanations of human phenomena - reduces the

tendency of misrepresenting or misinterpreting information on mental illness.

However, alternative mental health options constitute an important part of how members of social groups interpret socially defined signifiers of mental illness. The multiplicity of alternative interpretations that range from understanding causes and treatments of mental illness from spiritual, magical or traditional perspectives suggest that public beliefs about mental health is subject to constant change, depending on the ideological propositions of the dominant social group.

9.4.5 Available Information on Mental Illness

The motive here was to access information on mental health that respondents considered available. So far, the respondents opined that information about mental health is not enough or that knowledge about mental health is shrouded in some misconceptions. Jorm (2000) adopted the term mental health literacy to describe the knowledge and beliefs about mental disorder which aid their recognition, management or prevention. However, the substance of the

information considered available is connected to the following:

“There is quite a lot of media work going on you know things like ADHD, there are non – governmental groups now that are championing the awareness.” (Psy One)

The importance of the media as a source of information on mental illness reflects perceptions that are likely held about mental health issues. The media is shown as a major platform for the society to discuss salient social issues that would have hitherto been silenced (Gamson *et al.* 1992). The media is considered the source for credible information about mental health (Clement *et al.* 2013). However, the media is also perceived as more concerned about elaborating negative views about mental health (Philo *et al.* 1996; Rose 1998; Wahl 2003).

Psy Two, “ The most time when they talk about mental health is when reporting, especially that someone who is mentally ill did something, maybe committed some crime or whatever, that is the one they pick.

The use of the word ‘concise information’ in the quote below, in relation to information sourced from mental health care professionals suggests inequality in attributions made to the credibility of psychiatry and alternative mental health care options.

“But the only time they can provide concise information is when they invite professionals but it is not very common.”
(Psy Two)

In other words, available information about mental health is at parallel with scientific propositions on diagnosis and treatment of mental illness. Science based mental health care professionals are usually invited for comments in the media on mental health related issues (Jorm 2000), thereby, giving science-based mental health the opportunity to represent views on what should constitute social representations of mental health issues. From the comments, psychiatrists opine that media representations of psychiatry constitute a less negative portrayal of mental health. In the case of media content producers, media representation of mental health issues are affected by the desire for newsworthy or sellable media products (Henderson 1996).

Psy Three, “On the surface, it is assumed that they are informed but if you look at the approaches which people follow when it comes to mental issues, it comes in various forms, despite the ‘Community Outreach’ and the enlightenment programs like for example, we still see people seeking other means of treatment for the mentally ill individuals; from going to seek the help of a traditional healer, Muslim clerics or pastors in churches, despite the level of education of some family members.”

Mental health related issues are shrouded in a lot of conceptions that influence the attitude social members have towards mental health issues. Chen and Mak (2008) argue that cultural elements that determine dispositions to mental illness interact with the cognition of individuals in processing information about mental health. The above quote from *Psy Three* presupposes that information about mental health as suggested in mental health campaigns in the community or media may not be yielding the desired result. By implication, media messages that are produced by science-based mental health care providers may be targeted at actualising a cultural shift from the adoption of alternative mental health care, a move that has obviously not yielded the desired result going by representations of mental illness in movies.

Pro One, "I know that some in a culture, probably in a fetish way - you can make them loose their mental balance, state of reasoning, and of course if you go into drugs, if you go into like smoking hem, cocaine and all the rest of them, of course you can lose your mind."

In reference to the quote from *Pro One* above, a relationship between available information and constituted knowledge on mental illness exist. Shared belief that drug abuse and fetishism are associative causes of mental illness may be suggestive of a social belief exchange between adherents of science based explanations on one hand and alternative

explanations on the other hand. Gureje *et al.* (2005) reported that there exist a wide spread belief in drug abuse as a major cause of mental illness among Nigerians. They argued that reference to drug abuse as explanation of causes of some mental illnesses may have positive impact on individuals by restraining possible abuse of psycho active substances. Belief in drug abuse as causative factor of mental illness becomes negative when it implies that mental illness is self-inflicted and worthy of social condemnation (*Ibid*).

9.4.5.1 Predominant Beliefs

Pro Two, “If anything happens, like I said, I don’t even know where they traditionally heal mad people. I don’t know any. So, I just informed you of the case I experienced and my first referral was Yaba Psychiatric Hospital cause that is the first and most ideal place to first consult”.

Evident in the response above is the construction of possible reasons why belief in alternative treatment options are preferred to science based treatment options, even in circles where science based treatment is expected to be the first option at the onset of mental illness. This is evident in the statement below:

Pro Two, “And sometimes, I have heard of cases where and this is like coming from doctors, patients is taken to psychiatric hospitals, and they try every standard and

normal thing, and the person doesn't get healed. So, it is suggested to the person that would you like to try the traditionalists?"

From the report of the study by Gureje *et al.* (2005), belief in supernatural mental health views increases the possibility of seeking help from traditional and spiritual leaders; a move that may influence perceptions that help seeking from psychiatry is futile. The notion that psychiatrists suggest the adoption of alternative mental health option finds similarity in Atilola and Olayiwola's (2011) study of frames of mental illness in Yoruba language genre movies in Nigeria.

Pro Three, "There is a lot of information if you researched, that you could find useful and could be embedded in whatever you are doing."

Accessing psychiatrists' perception of available information on mental health has revealed that the media have effect on what people come to know of mental illness. Information in the media on crimes committed by people who are 'mentally ill' form part of the knowledge people have about the relationship that exist between committing crimes and suffering from mental illness (Philo *et al.* 1996; Rose 1998). In addition, science-based information on mental health, which attributes correctness of mental health information to science only, is more publicised by non-governmental organisations

and outreach programs that are facilitated and sponsored by scarce psychiatric facilities in Nigeria. In Nigeria, despite efforts put at increasing information about psychiatry, the popularity of alternative causal and treatment beliefs may remain unmatched by psychiatry.

For the producers of movies, the composition of mental health knowledge is in perceptions that mental illness is caused by both spiritual and scientific explainable factors. Illustratively, if a disorder is caused by magical incidents, the treatment pathway will be consistent with the identified cause. Drug abuse appeared to be dominant in what producers perceive could lead to scientific explainable causes of mental illness. Perceptions of ineffectiveness of science-based treatment of mental illness suggested the superiority of alternative mental health care among movie producers. The source of this belief is unknown; however, medical practitioners are often reported as suggesting the use of magic in treating difficult health situations that science ‘cannot’ cure, simply because the causes of such illnesses are assumed to come from magic.

Also, according to producers, information on mental health is available for as long as effort is made to engage in research. However, report from other studies explained that producers of television content consider research a hindrance to the pure process of making watchable TV drama (Henderson 1996; Jorm 2000), an aftermath of which may result in refusal to engage in research before representing mental illness in narratives.

9.5 REPRESENTATION OF MENTAL HEALTH IN THE MEDIA

In analysing perceptions held by psychiatrists, psychologists and movie producers/directors on media representations of mental health issues; themes such as ‘media’, ‘movies’ and ‘mental health’ enhanced the identification of word clusters that fall in this category. Meanwhile, four sub-categories emerged under this category: 1) perceptions on media representations of mental health issues; 2) perceptions on media function in portrayals of mental health issues; 3) portrayal of symptoms of mental illness in the media; and 4) influence of the media.

9.5.1 Perceptions on Media Representations of Mental Health Issues

The media has been identified in the analysis done so far as one of the sources of information on mental illness. Thus, perceptions and views of media depictions of mental illness are central to this sub category. Depictions of mental illness may be looked at from both positive and negative perspectives. The positive depictions are media portrayals that suggest that representations of mental illness are accurate and representative of wide spread perceptions of mental illness. The negative media depictions refer to portrayals that suggest that media depictions are not accurate representations of mental illness as understood by different social groups in the society. This includes representations that support or negate science based or alternative mental health care options.

Psy One, "I think the way the mentally ill are being depicted in the movies is still archaic. The presentation as in the movies is derogatory. I think archaic is the word. The movies are an emphasis or an exaggeration of psychotic distress that is meant to amuse basically."

According to Atilola and Olayiwola (2011a), the use of the word 'archaic' in the description of media representation of mental illness was in reference to alternative mental health. The perception of media representation of mental illness here

is negative as archaic also include references made to symptoms of mental illness not included in scientifically proven descriptions of psychotic distress. However, use of the word, 'emphasis' to describe movie representations of mental health may evoke multiple interpretations. One of such interpretations is that images of mental illness in movies are accurate ways of expressing madness, with emphasis observed in the adoption of certain symptoms of madness over many other possible symptoms. In this study, some of the movies on mental health produced in Nigeria had recurring symptoms of mental illness across different narratives. The recurring symptoms were: vagrancy, unkempt appearance, over elation, regressed behaviour, and incoherent speech, which featured above 50% across the analysed movies. This report supports the investigation carried out by Atilola and Olayiwola (2011a), where symptoms of mental illness in the order of vagrancy, poor grooming/dressing, talking/laughing to self, unprovoked aggression, regressed behaviour and incoherent speech were observed to feature as the most recurring symptoms of mental illness across 103 films. The similarity in the two independent reports complement references made to media portrayals as reproducing and invariably, emphasizing some specific symptoms of mental illness over others.

Psy Two, "Sometimes, the media exaggerate the reports through the headlines when eventually the reports states otherwise. The media have some level of blame which is peculiar to wanting to make more money and sometimes ignorance."

The indication that representations of mental illness are influenced by the desire to produce marketable products, point to the theory of commodification in the political economy of communication (Mosco 1996). The value in media messages is not restricted to profit making alone. However, shaping of consciousness that appear as an inherent symbolic and imagery production feature of media messages make the media a site of struggle (Gamson *et al.* 1992) for various interest and political groups. Also, Henderson (1996) argued that media products undergo series of negotiation process that affect media outcomes. Some of the factors that affect media outcomes may include personal and organisational interest; politics of economy; the need to attract and retain audience interest; the structure of social groups; and the kind of media product that is to be made.

In the quote below, the respondent explains how, as a professional, they understand the limits and value of media representation:

Psy Three, "I have seen a couple of movies where people have to feign mental illness the way it is feigned, it is just for the people to see that this person has mental illness but the treatment modalities and interventions is not feasible because they might not have contacted an expert who would have been able to use the normal terminologies or actually draw a conclusion about how to manage such conditions. It is just a normal general practitioners view or approach towards the treatment of mental illness. I have seen a couple of movies where by they present a fair presentation of mental illness but not as expected..."

There is the perception that the portrayals of mental illness in the movies are positive: images used in the portrayal of mental illness are fair enough for creating socially agreed upon themes and images required for the signification of mental illness. On the other hand is the negative approach to viewing media representations of mental illness, which implies that failure to tap from scientific explanations of mental illness will yield poor diagnosis and treatment prescription of mental illness. Furthermore, the quest for narrative pace in media productions bring about the conjuring of a representational identity for mental illness, in such ways that specific themes of madness are emphasized over others. This has been established in the quote below:

Pro One, "When you are making a movie, we have to put what we call suspense to hang people, your audience, you have to hang them in a way that they will sit tight

and want to see how you are going to come out with a solution.”

Devices of intrigue and suspense are considered essential in the production of sellable media products that will attract and retain audience interest. In the interest to attract and sustain audience interest, symptoms of mental illness may be misrepresented or exaggerated. In the same vein, some frames of mental illness in media representations are perceived to emphasize negative aspects of the culture. The negative part of the culture here refers to spiritual causal and treatment explanations of mental disorder. From the quote below, there appears to be an agreement between producers and mental health care professionals that media portrayals of mental illness from alternative views are negative, although, this view is not held by all the producers.

Pro Three, “I don’t know of many movies with mental themes. Most of the ones that I have seen tend to exploit the negative aspect of our culture and then the mental cases are suggested to have come from people who have caused people spiritually for certain reasons, some of which are a sort of retribution of some of their past, maybe what they had like a fight or something and have thus being afflicted with mental condition which for me is more fabrication than reality which suits a particular situation.”

In the above quotes from the *Psy* respondents, depictions of mental illness in the media are ‘archaic’, ‘derogatory’ and ‘exaggerated’. Similarly, reports from some empirical studies (Henderson 1996; Knifton and Quinn 2008) have shown that the portrayal of mental illness in the media is ‘unrealistic’. Although, differences in the descriptions of media representation of mental health exist, the use of ‘archaic’ or ‘exaggerated’ by respondents in this study is similar to perceptions that suggest that media portrayals of mental health issues do not represent views held by psychiatry.

9.5.2 Summary on Perceptions on Media Representation

The interview results suggest that science based professionals in the delivery of mental health care believe that drive for profit by movie producers influence portrayals of mental illness in ways that contravene scientifically acceptable explanations of causes and treatments. The professionals uphold the belief that unscientific information on mental health is inappropriate for audience consumption. Thus, the superiority of science over culturally accepted alternative modes of diagnosing and treating mental disorders is suggested in the interviews.

However, it can be argued on one hand that images of mentally disordered characters are conceived in the media in order to create an understanding of mental illness in the audiences – or how else does a producer or director depict or represent a character as different from the others; or that a character is suffering from mental distress. In the movie *Elulu* for example, the mentally ill character (*Gbeminiyi*) appeared different in outlook - wearing a combination of mismatched outfit; incoherence in speech; and vagrancy. Another mentally ill character in the same movie was made to appear with a dishevelled hair, dirty clothes, and was also vagrant. Thus, vagrancy, unkempt appearance, incoherent speech as stated earlier, appear to be more common in ways producers create images of a mentally ill character.

From the views of respondents, represented treatment options of mental illness in movies are ‘not feasible’. Media references to treatment of mental illness are considered incorrect or misplaced by science experts. On the other hand, some depictions of mental illness in the media are considered fair by science professionals. Although, access to what is fair in such depictions can only be assumed are references made to science based explanations or a deliberate reference to

subtle display of psychotic symptoms of mental illness, which conform to science-based outlines of how such diseases work.

On the other hand, movie producers argue that depictions of mental distress in the movies are needed to create suspense in narratives. Suspense is perceived as a major characteristic in narratives that incite and sustain interest. In the movie *Obiripo*, the male lead character (*Enitan*) constantly showed sign of unhappiness for reasons unknown to his wife. After much pressure from his wife to disclose the reasons for his constant repose to depression and insomnia, he takes his wife on a trip to the village where he reveals that his mother is mentally ill and has been living in the street since he was a student in the University. A major suspense in *Enitan's* revelation of who his mother was could be found in scenes where *Enitan* parked at clearly unusual places like a dump area in search for his mother. One would expect that homes or hospitals would be referred to as places where *Enitan's* mother lives. However, the narrative choice to refer to the dump site or areas under the open sky reflected an adoption of suspense in the process of telling a story about the status of the mentally ill character (*Enitan's* mother). This may also be reflective of what is obtainable in real social settings. In the movie *Tears of Madness* and *Ire Aje*, similar reference to

the mentally ill preferring to habituate in sites for dumps was represented.

However, producers have suggested that depictions of causes and treatments of mental illness in the media are more of fabrications than reality in its exploit of 'negative aspects of the culture'. Reference to negative aspects of the culture are in images of mental illness that explains causes and treatments of mental disorders from magical, spiritual, or traditional views. It can be observed in this analysis that producers appear not to have an agreement on what constitutes the appropriate way to depict mental illness. This suggests that alternative and science-based beliefs are held by producers, but that the majority of the movie content that represent mental illness in Nigeria suggest an adherence to alternative beliefs. As argued by Cross (2010), images of madness are historical and every social group, based on its historical period, will have its own way of seeing and understanding what madness or mental illness should look or appear like. A representational identity of madness is formulated within social groups, which constitute sources from where meanings of signs or symbols that evoke familiar interpretation of madness are constructed by producers.

9.5.3

Perceptions on Media Function

From the review of literature, it has been observed that the function of the media is relative when put in media user and content producer perspectives. Difference in perceptions of media role in representations of mental health issues have been analysed from the quotes below:

Psy One, “Maybe in terms of improving the presentation of this hospital (Yaba Neuro-Psychiatric Hospital), the media has actually a lot of important role to play.”

A recurring perception of the media is that it is required to function as a source of popularising evidence-based mental health care modes. This view is largely expressed by social groups that uphold belief in psychiatry (Gureje *et al.* 2005; Demyan 2009; Clement *et al.* 2013). In the context of basic structural factors that affect negotiation processes involved in the production of media contents, representation of science-based mental health care options in movies may be difficult. This is partly because production of media contents is often targeted at satisfying basic producer and media user interest. Read, Adiibokah and Nyame (2009) argued that responses to mental illness are influenced by social norms that emerge from historical, cultural and symbolic practises of Africans. If there is a cultural perspective of mental health that is dominant among the people, it may be difficult for producers

to risk the presentation of media messages with ideological framework around mental health that social members are not familiar with. Thus, doing this may mean risking the possibility of rejection by target audience. This in itself will have consequence for making decisions to produce media messages either for profit making or audience acceptance.

One of the few possible ways to get media content producers to frame mental health representations in ways that satisfy the beliefs of psychiatry may require financial involvement in movie productions. Gamson *et al.* (1992) argued that commercial concerns dictate important element of media content. However, the acceptance of selective representations of mental illness by social groups who hold spiritualism or magical beliefs superior to all other forms of belief may be a little difficult. Details of this position can be found in the comment of the neuro-psychiatrist below:

Psy Two, "The access to the media is not so much available basically if it is the hospital that wants to say something to the media, you may even have to pay to do it. And the hospitals probably have funds which are for so many other things, and these funds are not so much. Basically, it may not be so easy for them hospital) to do."

Views that media messages are constructions of social reality are central to perceptions held about media portrayals of mental illness. According to Gamson *et al.* (1992) media generated images are used to construct meanings about political and social issues. It is believed that the body of knowledge that are injected into media messages emerge from socially constructed and recognisable symbols and languages transmitted and maintained in social situations (Berger and Luckmann 1966). The sociology of knowledge proposed here is related to the notion that media messages emanate from the society and makes attempt to give back to the society what has been found to exist in the society. It is through social constructions of mental illness that social interactions can influence ways mental illness is conceived and understood within social frameworks (Burr 1998). A psychologist explains why this is so below:

Psy Three, "It is two ways, the media guys are an offshoot of the society, and they are part of the society from their experiences. And it is from their experiences, goals and objectives that they come up with news that they report to the society. As a journalist, you have to do research, interact and get information, put it together and then actually report it. It doesn't come from the blues or it doesn't come from the sky. You have to interact with the people, draw your conclusions, draw your inferences and do your report – then inform. It - who is influencing who can be said to be is vice – visa. The big questions are; is it

representative enough? Is it actually happening or is it true or false?”

A contending issue that keeps surfacing in arguments made against the portrayal of mental health in the media is attribution to poor research (Henderson 1996) by producers who produce images of mental health. The producer below believes that:

Pro Two, “A lot of people in this industry are not trained. They are just telling their stories from their point of view because they don’t even have the resources to do a lot of research, so they care less about it and they follow these tradition of what they have seen and how they have seen it, and people that have done it in the past. So if anybody wants to portray a mad person in the film, they will tie them and they will take them to where they are chained to the tree or rather if that is the way it is portrayed.”

Reference is made to the localness of experience (Burr 1998): where tradition, social values/beliefs, and historical perspective on mental health constitute the continuum from where representations of mental illness are extracted, regardless of the existence of alternative beliefs in mental health that propose ideas that differ from the general belief. This gives a foundational explanation to why a similarity exists in reports from this study and other studies (Aina 2004; Atilola and Olayiwola 2011a) on constantly reproduced

themes on symptoms, causes and treatments of mental illness in narratives.

Contrary to existing beliefs that the media portray mental health negatively, there is the belief that the media should as matter of primary function make products that are 'meaningful'; form agenda for development; promote; and preserve the cultural values of the social group of the members that media products are created for. This is evident in the comment from a producer below:

Pro Three, "The media should be concerned about societal issues. In other words, media should be making meaningful product, meaningful to form agenda for development and I think the media can do more. And right from inception, we had a mission statement in Mainframe production that we are going to try to promote and preserve our culture and that we are going to make socially relevant movies, which is consistent throughout all of our films. We need to encourage the media to start making socially relevant films or media."

Culture is a significant factor in the way madness is conceptualised and stigma is manifested (Abdullahi and Brown 2011). The call for developmental communication as a major function of media content production inspires an understanding on why media messages represent madness the way they do. In the bid to produce socially acceptable

messages, producers tend to adopt social representations of mental illness. Thus, movie producers believe that the media are required to frame media messages in ways that reflect dominant perceptions on mental health. On the other hand, if science-based treatment is believed to contribute to the development of mental health care in the society, the developmental function of the media then resides in the creation of media messages that support the adoption of evidence-based mental health care and vice versa. However, the argument found in a number of studies (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011a; Atilola and Olayiwola 2011b) on media portrayal of mental health issues in Nigeria, have often been described as negative media representations that attribute causes and treatments to beliefs that run contrary to psychiatry.

9.5.4 Summary on Perceptions on Media Function

Summarily, the quotes from producers, psychologists and psychiatrists suggested that the media should function to promote mental health care in the society. Furthermore, the media is expected to make science based mental health care system popular. Accessibility to the media by mental health service providers who may want to disseminate information

on psychiatry is considered poor. A perspective from the *Psy* specialists suggested that media contents are subject to the background and experience of the person(s) producing or directing a narrative. Also, Media content producers emerge from a society and do not fall from the sky i.e. producers are subjected to normative socialisation. Normalisation, as explained by Foucault in Barker (2004) refers to a process where docile bodies are subjected, used, transformed and improved within social practices and discourses. Thus, the contents of stories that are told, the explanations offered and the actions suggested in narratives found in the media will be subject to the information about mental health that producers are predisposed to.

It is in this vein that the *Psy* respondents suggested that content producers should research on topics relating to mental health before proceeding to writing stories about mental illness. Results from the interview showed that learning about components of science-based mental health care - from the point of view of the service provider and service user - should form integral part of the pre-production process of making media messages on mental illness. In other words, media function is perceived more in societal development through production of media materials that will

contribute to the promotion of good health values (Wallack 1981; Brodie *et al.* 2001).

When put in proper perspective, developmental values as it pertains to mental health views are relative and differ from one society to another. Absolute absorption of psychiatry in the Western nations may have occurred, but in African and Asian cultures, alternative views of mental illness are social nurtured and accepted alongside psychiatric views. Thus, the view held by science-based experts that alternative belief in mental health is negative (Aina 2004; Atilola and Olayiwola 2011) or the claim that science-based mental health options are superior to alternative mental health care methods or views is suggestive of cultural imperialism (Wig 1999). Cultural imperialism becomes more manifest when medicine, a branch of science that appears more as a western culture, is perceived as the only provider of universal solutions to all health-related problems, forgetting that these African cultures related with these diseases in their own ways before science came to the shores of Africa. The assumption that Western culture is the pinnacle of human thoughts is to attribute imperialism to western culture (Matheson 2009), the consequence of which is the belief that all other cultures are backward, uneducated, superstitious, old fashioned (*Ibid*),

unscientific and ineffective in solving social problems, a claim this study argues against

Finally, producers of movies opined that the influence of the media is shown in their drive for contents that will enhance profit. Although, most producers were described as poorly trained, interest in research as a means to present informed images of mental health issues are often overwhelmed by the desire to attract more audience. In light of this, Aina (2004) argued that media framings of mental illness are reminiscence of age long portrayals of mental health issues. Problem definition, causal diagnosis, effect of causes and remedy suggested in mental health framings (Entman 1993) of narratives may share similarity with images of mental illness from the past (Cross 2010). By implication, refusal to engage in research by media content producers may have led to the persistence of specific images of mental illness, which may be argued, represents what producers have come to know of mental health. It could also mean that media depictions of mental health, which are similar to past portrayals of mental health in the media, are as a result of the continued existence of a particular way of seeing, understanding and interpreting images of mental illness. According to the producers interviewed, it is believed that the

media has agenda setting functions, which require media producers to provide media contents that will encourage actions needed to promote favoured policies on social issues (McCombs and Ghanem 2001 in Entman 2007).

9.5.5 **Portrayal of Symptoms in the Media**

Mental illness is observed in a sufferer in the exhibition of what has come to be known of symptoms of mental disorders in a given society. The ability to carry out an on-the-spot diagnosis of mental disorder by individuals of a society is tied to various avenues of learning. In the quote below:

Psy One, "It is an exaggeration of a person who is supposed to be in psychotic distress: you see somebody scratching himself, behaving abnormally right there in the public, tearing clothes, looking tattered and rugged, killing, wanting to kill, crushing, breaking and someone people are running away from, living in dilapidated buildings, living in uncompleted buildings, being sexually molested, abused and raped by 'ritualists' and all stuffs. That is the depiction of the mentally ill and the picture in the media."

Some images of mental illness have been identified by the psychiatrist as often depicted symptoms of mental illness. The portrayal of the mentally ill as identifiable characters through images that present attributes such as: bizarre behaviour; violent behaviour; vagrancy; and victims of sexual

abuse, correlate with symptoms found in movies produced in Nigeria (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011). Violence as a recurring theme of mental illness in the media has been reported in many studies carried out in the Western society (Wahl 1992; Knifton 2008). In this particular study, violent themes were present but not dominant. Thus, violence is a theme that can be found in the movies, but not a dominant one. Reports from Atilola and Olayiwola (2011) showed that unprovoked aggression featured as the fourth most common represented symptoms of mental illness in twenty-three Yoruba language movies. For better contextualisation of this argument, the mentally ill character (*Gbeminiyi*) in the movie *Elulu 2* beat his wife as a sign of re-emergence of mental illness. In the same movie, *Gbeminiyi* was presented as an object of violence from another mentally ill character.

Another characteristic theme of the mentally ill that appears to be emerging in narratives is portrayals of mentally ill characters as deserving of mental illness. The perception is in the idea that mental illness emerges as a consequence of some bad action that had been undertaken by the mentally ill in the past. The concept of attributing blame to the mentally ill for the emergence of mental illness has been observed

more in causes relating to drug or substance abuse (Gureje *et al.* 2005). The psychiatrist below stated that:

Psy Two, "They just go ahead and most of the time, they portray someone who has a breakdown as someone who has done something bad, so it is a punishment for that thing or somebody somewhere want to harm him or whatever. For newspapers, what is common is reporting something and most of the time it is negative."

In the present study, analysing basic stigmatic portrayals in the movies showed that three (23.1%) mentally ill characters are to be blamed for the emergence of mental distress. In the movie *Obiripo*, *Enitan's* step mother was at the end of the narrative, shown to develop mental illness from sighting *Enitan's* mother. The narrative explained that *Enitan's* mother became mentally ill from consuming an enchanted meal prepared by *Enitan's* step mother. However, the magician (*ifa priest*) who prepared the magical substance in the enchanted food gave a warning that sighting a fully recovered, but once mentally ill *Enitan's* mother, will cause her to become mentally ill. In other narratives analysed in this study, reference to the mentally ill as blameworthy was present in the movie *Ore Meta Were Kan*. Mental illness in this movie was presented as emerging as a result of greed, while in the movie *Egwonga*, the mentally ill character was blamed for the emergence of mental illness for defying the demands of a deity. Thus, causes of mental illness are ascribed to being

bad. In other words, an underlining theme in the statement made by *Psy Two* above makes reference to perceptions that suggest the ability of an individual to evoke the emergence of mental illness magically in others.

According to science-based mental health service providers, portrayals of symptoms of mental illness in movies are exaggerated. The description of exaggerated symptoms of mental illness as they differ from correct representations of symptoms was not established in this study. Exaggeration from the point of view of the *Psy* respondents may be as a result of incorrect diagnosis of mental illness in the media. For example, symptoms of depression may be put across as symptoms of schizophrenia in narratives - information that may probably stay with viewers that do not have background knowledge of the differences that may exist in symptoms of various mental disorders.

From the responses above, science based mental health care providers perceive depictions of mental disorder as attempts made at establishing meanings that suggest that a character is suffering from mental illness. From their point of view, audiences are not entirely passive in media content selection

and retention of media messages (McQuail 2013). Reports from this study suggest that audiences are expected to understand that producers are required to show symptoms of mental illness the way they do in order to express desired meaning(s). This can be found in the quote below:

Psy Three, "It is just a movie because they are definitely actors. It is just to portray a particular scene in a film. Probably, where you see the person been tied down on the bed, he or she is displaying some abnormal behaviour which any other person will be able to pick, there and then you don't need an expert to tell you this person has mental illness, because he or she exhibits overt behaviour which is observable, you don't need an expert to tell you. Where an expert is needed is in the intervention method where you sometimes see the patient been sedated with an injection and immediately he calms down in the movies. At least, they have done an intervention method to arrest the restlessness or the violent approach"

However, salient questions that could be asked are: are audiences equipped to know that depictions of mental illness in the media are true or not? What happens when the depiction in the media correlates with prior knowledge of mental illness that the audience have? At what point are depictions of mental illness fit to be categorised as 'exaggerated'? According to the psychiatrists, portrayals of science-based interventions represent good portrayal of mental health. What then constitutes poor portrayal of mental health intervention in the media? Further empirical

study on media portrayals and mental illness may explore answers to these questions.

Pro Two, “For me sometimes its, when you are shocked beyond, for me, I would rather depict it in a subtle way where you just look on. Its seems you are staring but you are not staring at anything in particular, and because you have your brain already messed up, and for me, that is the best way I could portray such situation.”

However, disinterest in researching mental health by producers may be motivated by the drive for profit. In conclusion, the need for narrative flow in movies may influence ways content producers choose to represent symptoms of mental illness (Henderson 1996). Also, the body of the story and the desire to sell may impact on choices made to do research or not.

9.5.6 Analysing Perceptions of Media Influence

The motive of this analysis was to highlight perceptions of power that is attributed to the media. Psychiatrists, psychologists and producers are either consumers or producers of media content at various instances. For example, in situations where research about mental health is carried out before movie producers write stories with themes on mental illness, mental health care professionals in this

instance are indirect producers of media content. When movies are produced to promote science-based mental health care largely because of sponsorship – perhaps from pharmaceutical companies who benefit largely from the sales of psychotropic drugs – *Psy* professionals become media content producers. Thus, views held by scientists on the assumed or actual power of the media is crucial. Movies sponsored by mental health care providers are scarce and rarely available in Nigeria. This may be partly due to the poor funding of mental health care in the country (mhLAP 2012). However, other platforms such as the radio and television are adopted in Nigeria to provide information on science-based mental health care (Armiyau 2015).

In western countries, fictional narratives on mental health issues are often in the form of intervention films produced with the intent to reduce negative attitude towards mental illness among members of the society (Kerby *et al.* 2008; Clement *et al.* 2013), some of which are effective or not in reducing stigma. The media occupy a central component in the generalisation of specific voices across a range of cultural expressions (Gamson *et al.* 2002), where producers of media content employ the use of their own codes to symbolise discursive materials that are sourced from somewhere else

(Price 2007). Content of media productions are meaningful to the listeners, readers or viewers when there is a symbolic exchange between producers and the audiences (Price 2007). It is within this context that the psychologist below noted that:

Psy One, "I believe that the way the movies depict mental illness is the way the society see mentally ill people"

Representation of mental health in the media is perceived by the psychologist above to find similarity in social representations of mental health. Depictions of mental illness in the media may become difficult to understand or interpret when such depictions are at variance with the body of knowledge that aid identification, causal attribution and treatment suggestion of mental illness in a given society.

A recent study into the perception of mental illness among Nigerians showed that causal attribution of mental illness is largely spiritual, magical or traditional (Gureje *et al.* 2005). Reports on frames of mental health in entertainment media, particularly movies produced in Yoruba language, showed that causal agents in movies predominantly revolve round magic, supernaturalism or spiritualism (Aina 2004; Atilola and Olayiwola 2011). The psychiatrist below expressed that:

Psy Two, "... many Nigerians actually think that what is usually reflected in the media is the cause of mental illness. That somebody is punishing somebody or it is a punishment for something bad that you have done in the past, i.e. diabolical reasons."

Psy Three, "The movie is expected to educate."

The perception of the media as a major source of information on health issues (Vogel *et al.* 2008) have been reiterated in the quotes above. The media is believed to be responsible for proposing how mental illness is to be identified and understood. Corrigan (1998; 2004) argued that negative portrayals of the mentally ill could reduce the possibility of seeking help for fear of being associated with negative themes in media representations of mental illness. Such negative representations include violence, danger and blameworthiness. As argued by Vogel *et al.* (2008), cultivation theory hypothesizes that exposure to media content (television) influence the general perception and specific attitudes towards vital social issues. Within this context, it is believed that the media are influential in the conceptions of social reality. Furthermore, the media is believed to have the power to effect cognitive and attitudinal changes in receivers of media messages.

The producer and psychiatrist below stated that:

Pro One, "We pick what we write about from our immediate environment, from what we hear, what we see, what stories that people tell."

Psy Two, "...people see these movies as what is happening in the public domain, so it will just probably entrench that believe in them that these person or somebody else is responsible."

Perceived power of the media in the influence of knowledge, beliefs, values, social relations and identities (Fairclough 1995) lie in the function of every distinctive media work, which entails reordering of *existing* codes, conventions and materials (Allen 1987) in social groups. Movies present narratives that retell human phenomena. In other words, movies extract meanings of images that exist in the society. The entertainment media, particularly popular movies, may be powerful in influencing attitude formation about mental illness (Owen 2012). Producers of media content are believed to possess distinct powers to tell stories in particular ways, different from all other possible ways of telling the same story. Thus, the power to inform, or misinform; and to represent or misrepresent becomes evident in ways narratives reorder social happenings. The producers below expressed the following views of media influence:

Pro Two, "To an extent, yes. And also, you are imposing your perception on people. That is what it is. So, it is left

for them to either take it or to condemn it, but the power is in your hand to say, look this is the way. People can now say, no, it's not the way. You have the platform to do that"

Pro Three, "That is the power of the medium itself and the media is very close to the grass root. If there was motivation and if there was consistency in series of movies around this subject matter. There is no doubt in my heart that there would be changes. We tried it and we practiced it and we just wish that there are many more like that."

On the other hand, an argument against an all pervasive media influence has been suggested in the quotes above. The media may possess the power to decide on what to say and how to say it, but audiences are varied, self-determined and possess the ability to filter influential messages (McQuail 2013).

9.5.7 Summary on Perceptions of Media Influence

Summarily, the *Psy* professionals are of the opinion that the power of the media is reflected when what people come to know of mental illness is influenced by media representations. One can explain this concept via the cultivation theory (Gerbner *et al.* 1986; Vogel *et al.* 2008). Some of the respondents believe that the power to influence function of the media should be utilised towards the

education of people about mental illness. The interpretation of education here refers to media framings of mental health issues in ways that suggest the superiority of science-based mental health care.

However, producers share similar views on media influence with the *Psy* professionals. The media is seen to possess the power to “impose” perceptions on social issues in audiences. This power is said to be observable in ways producers/directors carry out functions of producing media contents for viewers, regardless of preferences and needs of individuals or group members of a given society. Producers of media content decide on what to say; how it is to be said; why it needs to be said in particular ways instead of adopting myriads of alternatives; and the purpose for which it is said. However, producers believe that sources of stories produced in the media are social happenings that producers and directors are a part of. Thus, media contents are inspired by events in the society.

9.6 ATTITUDE TOWARDS MENTAL ILLNESS

In this category, perceptions of and attitude towards mental illness were examined in responses from interviewees. In this category, identified themes for the selection of word clusters were “belief”, “believes”, “spiritual”, “orthodox”, “traditional” and “scientific”. It is assumed that the belief system around mental illness among the respondents may or may not be similar. The hypothesis is that mental health care professionals would uphold scientifically proven mental health care options, while mental health beliefs held by producers may flow between science and alternative (spiritual and magical) mental health care options. The material below shows the belief system that can be found among professional mental health care providers and movie content producers or directors.

9.6.1 Perceptions of Mental Illness.

Perceptions of mental illness vary across cultures and social groups. Psychiatry is a practice that may be easily accepted in some social settings and difficult to comprehend or adopt in other social settings. This sub category examined perceptions held by *Psy* professionals on mental illness. These perceptions may have emerged from their interactions

with various users of science-based mental health care options; personal relationships; and personal beliefs. Views held by producers may be a reflection of what people believe or would do in situations that reflect the onset of mental disorder.

In this analysis, psychiatrists are of the opinion that the belief system around mental disorder in Nigeria is largely informed by magical explanations. People tend to believe that the causes of mental illness correlates with attack from angered gods. Belief in magical and spiritual causes of mental illnesses can be found in the knowledge fountain of the Nigerian society. The knowledge of magical causes is prevalent and passed on from one social group to another through various means – one of which is the media. These arguments are embedded in the quotes below:

Psy One, “Some will just believe that it is another thing entirely. That it is an attack from the gods or something like that.”

Psy Three, “I have seen a professor, who despite his exposure and education still believe that the problem of his son is spiritual, so rather than go orthodox, he decided to go spiritual and at the end of the day, the boy still had to be brought to the hospital after they have gone shopping round for treatment at various spiritual centres.”

Reference to the quote from *Psy Three* above suggest that relating acquisition of Western education with knowledge of science-based mental health is invalid (Gureje *et al.* 2005). Illustratively, movies analysed in this study affirmed the notion that the educated still believe in cultural explanations of mental illness. In the movie *Obiripo*, the character *Enitan* was portrayed as a western educated man. Despite his level of education, he could not think of a treatment option for his mentally ill mother. It took the intervention of *Enitan's* wife to come to terms with the adoption of a treatment option, thus the eventual treatment sought at a *specialist hospital*. In the same movie, specialist hospital was adopted to imply a combination of science-based and magical treatment modality that led to the cure of *Enitan's* mother from mental illness. *Enitan* as an educated character did not refute the adoption of both forms of treatment. Also, *Gbeminiyi*, in the movies *Elulu 1* and *Elulu 2*; and *Chiamaka* in the movie *Mad Couple* were educated characters that received treatment from different forms of alternative mental health care services.

Psychiatrists observed that educational level of a family member of a sufferer does not often influence judgements made about causes and treatments of mental illness. From the reports from psychiatrists, personal experience revealed

that highly educated Nigerians still belief in magic and spiritualism as acceptable causal and treatment explanations for mental disorder. Thus, despite access to scientific knowledge of mental health, some educated individuals choose to understand or interpret mental health issues in ways that are more *cultural*. Experience of efficacy in the use of science or alternative treatments of mental illness may or may not affect the level of preference that is given to one mental health option over the other.

The belief that perceived causes predetermine treatment options can be found in the comment of the producer below:

Pro One, "My belief! My belief is that if one gets mentally deranged via drugs and all that, if you go to a psychiatrists, they stop you and you are rehabilitated and they give you some other drugs that will make you balance, you can be cured, but if diabolically through fetish things somebody is made mad, you have to approach it from the fetish way."

Gureje *et al.* (2005) reported that believe in drug abuse as a causal explanation for the emergence of mental illness was found among Nigerians. However, the quote above suggests that mental illnesses that emerged from substance or drug abuse are pathologies to be handled by psychiatrist, while interpretation of causes of mental disorder in instances where

drug abuse has been ruled out, is fundamentally reliant on social representations of possible causes. As explained by Rashed (2013), social context is the actual context from where individuals draw fundamental interpretive frameworks and perceptual tendencies. The producer below believes:

Pro Two, “Sincerely, I might not be able to answer that because it depends on what frame of mind or rather the structure of the story. If I want to preach something, then I will preach what I want people to believe but really, I always like to balance whatever it is I do. But I believe so much in culture, I believe so much in the Yoruba culture and I am one of those who would totally condemn when anyone comes and says this is the only way. I always leave it open and you can see it in all my films. I like to show that everybody is entitled to their beliefs. In such case, it depends on what I want to project.”

For producers, mental health issues are nurtured by what is known as possible causes of a mental disorder. For example, if an individual suddenly begins to display symptoms of mental illness after a magical wand or words were recited, the established cause suggest that magic is the only treatment modality that can lead to partial or total remission of such mental illness. In other words, the identification of the root causes of symptoms of mental illness either from magical or psychiatric explanations, is a belief system that finds acceptance among media content producers. In analysing

factors responsible for decisions made in framing mental health in preferred ways, producers appear motivated to structure narratives to appeal to audience and increase profit. Thus, if belief in psychiatry will stir more suspense and attract more spectators, psychiatry may become the preferred themes of mental health that producers may choose to frame. However, one of the producers held the view that psychiatry is a productive and preferred way to explain mental health related issues in movies.

The tenets of culture and the desire to preserve cultural beliefs appear very important to producers. Producers conceive of themselves as preservers of Nigerian cultural heritage. In the analysis of responses, producers often have to decide between producing messages with or without the intent to influence actions or beliefs of audiences. In one respect, the media is regarded as powerful and capable of having a canonical effect on the recipient of media messages. On the other hand, media producers claim that they do not function to impose certain beliefs on audiences. However, meanings of media text are circulated in various ways and require influence of intermediary agents in the process of communication (Gamson *et al.* 1992; McQuail 2013). In other words, media messages generate different meanings.

9.6.2 Perspectives in Perceptions of Mental Health Issues

The focus here is to analyse attitudes of respondents towards mental health issues that may have resulted from interactions with sufferers or social observations. Despite the diversity in mental health beliefs that cut across science based and alternative (spiritual and magical) mental health care options, reasons for the prominence of a belief system over the other is unknown. Alternative mental health care options represent magic, occultism, spiritualism, supernaturalism as a belief system that guides social description of causes and treatments of mental illness. Magic belief is largely supported by many cultures (Subbotsky 2004); and is observed in physical alteration of animate and inanimate things. Individuals have been observed to uphold socially dominant causal beliefs of unusual happenings (Subbotsky and Quinteros 2002). Perceptions of belief in magic are deemed compatible with spiritualism and supernaturalism in the way social happenings are explained (Chireau 1997). Common features that can be found in magic include healing, spells, supernatural rituals, and conjuring relics (Chireau 1997).

Psy One, "The first thing of course is that, oh it is a spiritual problem and it is something that has been inflicted by diabolic means."

Psy Two, "The first one is the traditional or the religious to a large percentage of them, when you look at the part way to care. For quite a number of them, the first time they notice this, the first place they go to. Many still don't believe it is a medical condition. They think it is a spiritual problem or whatever."

From the quotes above, causes of mental illness, like many other social happenings among black culture, have deep root in magical or spiritual beliefs (Chireau 1997; Gureje *et al.* 2005). According to psychiatrists and psychologists, the pathway to mental health care differs from one person to another. What has been largely observed among users of mental health care facilities is that prior visits to spiritual healing centres are often made before visits are made to science based mental health care facilities. Thus, it can be deduced from the report that more of those in South-Western Nigeria, who use mental health care facilities, prefer to adopt magical or spiritual mental health care options before accessing psychiatry. This may be attributable to the view that some disbelief in mental illness as a medical condition (Foucault 1965; Szasz 1987).

From earlier submissions, believed causes of illness determine the treatment options people will likely seek. Responses show that there exists a perception that relates failure in the use of magic or spiritual mental health care to the incidental use of science-based mental health care. This can be found in the comment of the psychologist below:

Psy Three, "It depends - we are going to look at it from different dimension; some family members would actually take the individual first to a normal hospital and when they get there and the physician/ doctor there does his assessment and feel that he will not be able to manage it, such individual might be referred to this hospital. Like I said, some will also go to spiritualists for help and when they have tried those spiritualists, they still come back to the hospital and probably, some come here directly."

For example, in the movie *Ore meta were kan*, (a Yoruba language movie) the mentally ill character, by implication, became mentally ill from magical explainable causes. The victim (*Were Sharukan*) was portrayed as becoming mentally ill from a failed attempt at becoming wealthy through unconventional means of visiting an *Ifa priest* (a human who uses magic to distort natural course of happenings). In another movie *Egwonga* (an English language movie), the mentally ill character (*Ugomma*) became sick from a magical spell casted on her by a god that lives in an *enchanted tree*.

Another recurring perspective in perceptions of mental health issues showed that producers, out of fear of rejection by audiences, will probably not portray science as an option for the treatment of mental illness. Producers are interested in attracting and retaining the interest of audiences in their stories; and this priority impacts on the way narratives are structured around mental health themes. Producers believe that science-based mental health care options do not correlate with popularly held beliefs on mental health. As such, suggestions of science is feared may find rejection in audiences. The producers below said:

Pro One, "Yes, because it will be too, as far as I am concerned, for a story writer, it will be too weak. Our viewers are the problems that we have, they will not believe it. You know, if it is English or if I had belonged to another society that is not Africa, they will take it from me because we worked towards the woman being depressed and feeling that she is a failure and all that, because you can be mentally imbalance if you feel you are failing in life, time is going, how do I make it in life, you know you could feel, that kind of a thing can set in but then my society will not believe it. They will say that how can a thing like that make her mad, doesn't she have hands and legs, she can go out and work and make ends meet, they will not believe it. You have to attach some other things like bringing the junior wife to doing that bad thing and she has been told that anytime this woman gets remedy, the thing will come back to you."

Pro Two, Sincerely, I might not be able to answer that because it depends on what frame of mind or rather the structure of the story. If I want to preach something, then I will preach what I want people to believe but really, I always like to balance whatever it is I do. But I believe so much in culture, I believe so much in the Yoruba culture and I am one of those who would totally condemn when anyone comes and says this is the only way. I always leave it open and you can see it in all my films. I like to show that everybody is entitled to their beliefs. In such case, it depends on what I want to project.”

Thus, producers create relatable themes of mental health that will find acceptance from audiences. The audience may likely be disinterested in belief systems that negate culturally held views or suggest new ideas that are strange to social members. There is also the other part of movie production that involves the juxtaposition of cultural and science-based knowledge of mental health. The idea proposed here is the integration of different social values, beliefs and norms of mental health: the establishment of cultural integration as against cultural imperialism (Matheson 2009). The producer below stated that:

Pro Three, “We have really been very careful about the use of traditional help. Rather than that, we went to orthodox medicine and see how we can explain the situation in a way even if presented locally can be understood. We in Mainframe Production use our culture a lot, but then we want to bring it to contemporary times

and we try to analyse. For example, if you take a film like “thunderbolt” also “magun”, whether “magun” is a reality or myth. That film looked for a collaboration between orthodox and our traditional medicine. We suggest see if the two of them can work hand in hand, rather than one posturing as being superior to the other, and being arrogant about the monopoly of knowledge.”

For the purpose of illustration, the movie *Obiripo* reflected a merger between science and alternative based mental health care, a notion evidently supported in the suggestion of the producer quoted above. In the movie, the mental health facility that was visited for intervention combined the use of evidence-based and magical mode of treatment. The *specialist doctor* in the movie administered medications to the mentally ill and also used a magical object to cure madness. However, analysis from the interview also suggested that producers may prefer to produce narratives that support existing beliefs around mental health, while some others may attempt to make movies that suggest psychiatry. For some producers, an option is a merger between science and alternative mental health care modalities in the representation of mental health issues in movies.

9.7 STIGMATISATION IN MENTAL HEALTH

This particular analysis focused on the concept of stigma in mental health as conceived and understood by mental health care providers and media content producers. Themes such as; “stigma”, “prejudice”, “stereotype”, “discrimination” and “attitude” were adopted in categorising statements that referenced stigma. The sub categories under this heading are perceptions of stigma and manifestations of stigma.

9.7.1 Perceptions of Stigma

In this category, statements around stigma were quoted from a *Psy* and *Pro* respondents, simply because these respondents were the only ones that made reference to stigma of the mentally ill. Questions on stigma were not asked directly from the respondents during the interview. However, responses below were individual references to stigma that occurred in responses to other questions. The two respondents quoted below made references to both self-stigma (stigmatising attitude towards self) and public stigma (stigmatising attitude from others). Stigma as a concept was expressed by the psychologist to include ways symptoms of mental illness represent sufferings in the mentally disordered (Rüsch, Angermeyer and Corrigan 2005). Specific physical

outlook in people such as: unkempt appearance, dishevelled look and nakedness in public spaces are images that imply the presence of mental illness. Thus, a social selection process, through the identification of certain human qualities (Rüsch *et al.* 2005) that define and differentiate the sane from the insane, is engaged in. This is possible through the conceptualisation of a perceived difference that endorses stigma in mental health (Corrigan *et al.* 2015).

Psy One, "But a man whose hair is dishevelled, is probably walking naked and stuff is now totally assigned more stigma than that person who perhaps is just "hustling" to buy the next fix of drugs. Most of the people we call the area boys are actually drug addicts so that is one of the way we know that they have mental health issues."

Furthermore, stigma may occur in the way people who have used psychiatric facilities avoid disclosure of psychiatric experience in order to avoid stigma. In the quote below:

Pro Three, "People whom you can't even imagine will walk into the institution, it depicts people from all strata of the society are treated regularly, but because of the stigma, people don't say that they are patients."

Here, stigma is understood not only from the concept of been known as a sufferer, but extends to been associated with the use of evidence-based mental health care services.

Angermeyer *et al.* (2005) reported that people tend to rely more on treatment sources outside of psychiatry, with a corresponding increase in the preference for the use of traditional alternative treatment options. Stigma is also feared to be a reason why people may refuse to use science based mental health care facilities at all.

9.7.2 Manifestations of Stigma

Themes showing manifestations of stigma in media characters have been highlighted under this sub category. In references made to stigma in the previous sub category, certain physical outlooks have been described as identifiable signifiers of mental illness. The aim of this analysis is to explore ways symptoms of mental illness in the media are understood; and the perceived consequence or causes of these depictions in relation to stigma. In quotes from the psychologist below, the concept of stigma is tied to the way symptoms of mental illness are depicted in the media. 'Exaggerated' depictions of mental illness were in associating display of indecent public behaviour; excessive scratching; murderous tendencies; one who inflicts and receives sexual assault; and vagrancy to mentally ill characters. Media portrayals may encourage withdrawal from individuals that

display any of the aforementioned symptoms of mental disorder because these portrayals label mental illness in ways that evoke feelings of danger or violence (Jack *et al.* 2007) in perceptions held of mentally ill individuals.

Psy One, "It is an exaggeration of a person who is supposed to be in psychotic distress: you see somebody scratching himself, behaving abnormally right there in the public, tearing clothes, looking tattered and rugged, killing, wanting to kill, crushing, breaking and someone people are running away from, living in dilapidated buildings, living in uncompleted buildings, being sexually molested, abused and raped by 'ritualists' and all stuffs. That is the depiction of the mentally ill and the picture in the media. It is also stigmatizing; oh you shouldn't move close to him, you shouldn't help him, just stay away from him."

Popular perception of the mentally ill as *dangerous* and constantly displaying anti-social behaviour may be a manifestation of stigma by psychiatric standards (Corrigan and Watson 2002; Clement *et al.* 2013).

Furthermore, this study revealed that poor funding (3% of annual health budget) from the government may have contributed to the decline of quality mental health care services in Nigeria. Poor quality services that result from poor development and implementation of government policies may allow stigmatisation of mental illness to thrive. In a report by

Knapp *et al.* (2006), poor mental health care systems have huge consequences for the socio-economic status of a country. It is even envisaged that the level of stigma attached to mental illness may be contributory to the poor attention that mental health generally receives from government policies or voluntary organisations.

Psy Two, “No, like I said because all these things requires funds, many of the government and the NGO’s don’t partake in mental health care possibly because of stigma or there is not much money there.”

Psy Three, “But I think the government still has a role to play because when we talk about mental illness, we talk about stigmatization and a lot of people don’t want to associate with such conditions. It is one condition people tend to turn their face off from or shy away from.”

Pro Three, “...I am so disappointed that ten years ago we had better mental health care facilities than we do now and when I spoke to the Medical Director of the Yaba Neuro-Psychiatric hospital for instance, she told me that because of some certain problems, that the number of the patients in the hospital has even reduced considerably to not more than thirty and it is sad to know that presently, people living with mental illness are neglected.”

Finally, mental health care is said to be underfunded in Nigeria (Gureje *et al.* 2007). Mental health service development in Nigeria has been slow, despite propositions by the World Health Report (2001) for a mixed model of services

that will include mental health care in primary and specialized health care services (Saraceno *et al.* 2007). Also, government involvement in the development of alternative mental health care for treating mental illness has not fully progressed in Nigeria.

9.8 DISCUSSION OF INTERVIEW ANALYSIS

Analysing the perceptions of mental health care professionals and media content producers have revealed quite a number of salient issues around mental health in the Nigerian context. Mental illness is seen and understood differently by psychiatrists and movie content producers, and in some cases, similarities were observed. Science based mental health care professionals are trained to see and diagnose mental disorders using conventional scales or manuals (Porter 2002). In other words, the perception of how stigma or other related issues around mental health is perceived and discussed by psychiatrists and producers vary tremendously, due to exposure to science-based explanations on causes and treatment of mental illness that professional mental health care providers have.

Movie producers and mental health care providers agree that information on mental health is inadequate. This complements the report of the study by Gureje *et al.* (2005, p.440) that argued that knowledge about mental illness is very poor in the Nigerian community. Poor knowledge of mental health as argued by Gureje *et al.* (2005) was judged from the position of knowledge in psychiatry. Information that negates psychiatry clearly assumes the position of misinformation or poor information (Gureje *et al.* 2005). A framework for understanding the diversity in the way professionals in psychiatry and media content production perceive mental health related issues in the media and society can be found in Berger and Luckmann's (1966) theory on sociology of knowledge. According to Berger and Luckmann (1966), the sociology of knowledge is concerned with the relationship between human thought and the social context within which it arises, as human knowledge or consciousness is determined by social members. Thus, scientific formulations of what is real do not exhaust what is real for members of a society. As argued by the duo, the sociology of knowledge of mental health issues in various societies is better understood from social construction of what is real.

Thus, from the analysis, attitude to mental health in Nigerian society revolves round supernatural, spiritual and magical based belief systems. Supernaturalism and belief in magic are peculiar to African traditions that have refused to wane in popularity, despite the embrace of many Western traditions and beliefs by many African communities. Aina (2004) is of the opinion that the adoption of Western culture by Nigerians may be contributing to the decline in belief in magic and sorcery. However, the adoption of magic and sorcery as explanations for causes and treatment of mental disorders seem stronger than hitherto imagined (Heaton 2013b).

From the analysis, images of mental illness in the movies have a semblance with age long representations of both madness and healing. According to Cross (2010) images of mental illness that appear in the mass media today, reflect conceptualisations and representations of mental illnesses that have been around for centuries. For Cross (2010), media content producers simply carry on traditional depictions of the past, many of which are repetitions or residuals of long-standing popular beliefs about madness.

Depiction of mental health themes in the movies agreed with some submissions from previous studies. For example, the interview analysis showed that depictions of mental health in the media are exaggerated. Also, Henderson (1996) in her study noted that a major criticism against media portrayals of mental health is that it is 'unrealistic'. Exaggerations in the way symptoms of mental illness are presented share a similarity with 'unrealistic' portrayals of mental health in the Western media.

Although, Gamson *et al.* (1992) captured the influence of media messages in constructions of social and political meanings, responses from the respondents showed persistence of belief in power of the media in influencing attitude. This may have been possible through the use of the media to represent competing constructions of reality. Media constructions of reality are influenced by the needs and desires of media content producers, which are influenced largely by the need to make profit. In other words, commercial concerns (Gamson *et al.* 1992; Mosco 1996) influence the way mental health is framed in the media. Media content producers are constantly required to balance the needs and interest of the production crew; the medical profession; and the mentally ill (Henderson 1996), but, the

most important group will wield the most influence on how images of mental illness are framed.

CHAPTER TEN

CONCLUSION

10.0 GENERAL OVERVIEW OF THE STUDY

This study examined the representations of mental health issues in movies produced in Nigeria. The perceptions held by movie producers and science-based mental health care providers on media representation of mental illness, were central to this enquiry. The study focused on investigating processes involved in the production and reproduction of particular meanings of mental health. The prominence of specific forms of mental health representations over other possible representations in movies was examined in this study. Findings from this study revealed themes and perspectives of mental health that are majorly situated in films produced in Nigeria. Discourse analysis on the findings of analysed movies was compared with perceptions of mental health from key informants in movie production and science-based mental health care provision. This study has contributed to knowledge on mental health issues in Nigeria by examining representation of mental health issues from media and cultural perspectives.

In the same vein, disparity observed in Western and African perceptions of causes, treatments and stigma of mental illness in the media (Philo *et al.* 1996; Wahl 2003; Aina 2004; Knifton and Quinn 2008; Atilola and Olayiwola 2011) revealed the importance of incorporating cultural studies in explanations of media representations of mental health issues in Nigeria. Content analysis and in-depth interview techniques were used to assess perceptions of mental health issues that are held in Nigeria. In order to foster better understanding of social constructions and reflections of mental health issues, Critical Discourse Analysis was adopted to situate suggested meanings of mental health in movies; and responses of selected movie producers and psychiatrists (Chouliaraki and Fairclough 1999). Critical discourse analysis, ideological theory, framing and social constructionism were adopted as theoretical frameworks for explaining the results from this study.

The mental health care system in Nigeria includes both scientific and alternative causal and treatment modalities. In this study, it was revealed that movies poorly represent science-based mental health views. Poor perception of science-based options for explaining causes and treatment of mental illness among movie producers also exist. However,

science-based mental health care system is poorly developed in policy and service delivery (Okasha 2002), despite the presence of psychiatry in Nigeria since 1950 (Heaton 2013a). Details of mental health care system in Nigeria have been carefully examined in the second chapter of this study. However, result from this study showed that poor disposition to issues of mental health among Nigerians has a relationship with inadequate information on mental health (Gureje *et al.* 2005).

10.1 CIRCULATED MEANINGS OF MENTAL HEALTH

Social representations of certain identifiable images of mental illness, adopted in examining the sanity of individuals are critical to understanding madness as a concept. Identifiable images of the insane (Gilman 1988) that describe them as violent, dangerous, vagrant, unkempt, bizarre, childlike and blameworthy (Wahl 1992; Philo *et al.* 1996; Aina 2004; Knifton and Quinn 2008) characters have influenced standards adopted in the evaluation of individuals as sufferers of madness, an extension of which permits laymen and specialists to see the signs of danger and illness everywhere (Foucault 1965). The adoption of madness as a grass root construction of lunacy, insanity, psychosis or

mental illness has inspired consistent perceptions of mental illness through ages (Cross 2010): from the Middle Ages to the period of Renaissance (Foucault 1965); the fifteenth century (Gilman 1988); and to the twenty first century (Heaton 2013a), a persistence Cross (2010) argues, emanated from the social preservation of images of madness from the past to the present. The instantaneous identification of mental illness in the East and West; similarities in perceptions of madness across cultures, nations, tribes; and social production and reproduction of mental health beliefs give credence to the submission that social representations of madness is age long.

In this study, results from the analysis of movies has shown that representation of mental illness in the movies have recurring themes that the producers prefer to rework. Mental illness in the movies has recurring themes that suggest specific meanings about mental health. Analysis of media representations of movies produced in Nigeria, with particular emphasis on Yoruba and English language movies, have confirmed the prominence of spiritualism or magical beliefs in explanations of causes and treatments of mental illness (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011). References made to full recovery or remission of symptoms of

mental illness from alternative (spiritual or magical) treatments reinforce perceptions of success or efficacy movie makers attribute to magical and spiritual beliefs in the narratives. Movies produced in Yoruba and English languages in Nigeria share immense similarity in representations of identifiable symptoms of mental illness. The dominant themes of mental health symptoms were incoherence in speech; vagrancy; hallucination; unkempt appearances; mental retardation; and regressed behaviour. These themes were largely adopted in evoking interpretations of mental illness in movies. Thus, similarities in ways images of the mentally ill are constructed across narratives suggest imposition of certain criteria as symptoms of mental illness that needs to be present in narratives with mental health themes.

In an attempt made to investigate possible differences that may occur in representations of mental illness in English and Yoruba language genres, analysis in this study do not suggest any significant difference in ways producers of English language movies choose to present causes, treatments, symptoms and stigma of mental illness. The importance of investigating a possible difference in the English and Yoruba language movie genres lay in the view that most of the

English language movies that were analysed foregrounded the Igbo culture, which was different from the Yoruba culture that was foregrounded in Yoruba language movies, with the hope that differences or similarities in cultural representation may have consequence for understanding movie representations of mental illness in Nigeria.

Also, from this study, perceptions held about mental illness in movies and interview responses suggest recurring references made to consequences of *badness* or *evilness* as a possible causal factor of mental illness. Thus, this study suggests that in the western media, being *bad* has often been related to been *mad* (Wahl 1992; Philo *et al.* 1996; Cross 2014) but, movies with mental health themes produced in Nigeria often present being mad as a consequence of been *bad*. This view is particularly important in fuelling the ongoing debate on *bad* and *mad* theory that can be found in analysis of western media representations of mental illness (Wahl 1995; Philo *et al.* 1996; Cross 2014). Also, the view that the Nigerian perception of *mad* and *bad* is more of *mad* being a consequence of being *bad* may further help psychiatry to understand how madness is pathologized in the Nigerian culture, thus contributing to the corpus of cultural psychological studies.

Evident in the analysis of this study are representations of the mentally ill as victims of violent actions such as physical assault, sexual abuse and magical manipulations. Thus, ascription to violence in movies produced in Nigeria does not correlate with themes of murderous tendencies that can be found largely in depictions of the mentally ill in Western fictional materials (Wahl 1992; Philo *et al.* 1996). The subtleness hitherto adopted in referring to the mentally ill as violent, but, not murderous is important to deconstructing *dangerous* as a dominant way of describing the mentally ill. Milder references to violence in relation to media representation of mental health issues in Nigeria may be attributable to causes of mental illness that are emphasized culturally. Similarity in conceptions of madness in Nigeria and the UK in relation to themes of violence, blameworthiness or weakness, but with varied degrees of representation, was evident in the result of this study. Perceptions of violence portrayed in Western media appear different from representations of violence in African media. In Western media, representations of the mentally ill as violent murderers or homicidal maniacs are different from the subtle references made to the mentally ill in this study as receivers of violent act; and perpetrators of violence in provoked and unprovoked situations. It is believed that subtle reference to

violence in relation to mental illness may reduce the popularity of *violent*, *dangerous* or *murderous* themes in stigmatic media representations of mental illness. In other words, concepts of madness in media representations of mental health issues in Nigeria share some similarities with perceptions of madness, lunacy, mental illness or insanity that can be found in many other social groups and settings (Wig 1999; Subbotsky and Quinteros 2002; Rashed 2013).

In this study, psychiatry only can be said to be poorly referenced in the movies. This was evident in the low references that were made to scientific diagnosis and treatment options that may lead to recovery in the narratives. Thus, this study is arguing for the view that knowledge about mental illness in the movies cannot be generalised as poor as argued by Atilola and Olayiwola (2011) and Aina (2004) if it is only representations that are indicative of psychiatry that are lacking in the movie representations of mental illness. As suggested by previous researchers (Aina 2004; Gureje *et al.* 2005; Atilola and Olayiwola 2011) and confirmed in this study, efficacy in the adoption of alternative or traditional modalities of identifying and treating mental illness appear popular among movie producers and in movie content. The popularity of alternative views thus suggests the dominance

of alternative mental health which constitutes an important source of knowledge and action for movie content producers. If alternative view is predominant among Nigerians, then it constitutes a socially accepted knowledge of mental illness. Thus, the less prominence of psychiatry among Nigerians or in movie representations cannot be inferred as suggesting poor knowledge of mental illness generally.

In other words, this study argues that African belief in magic, supernaturalism and spiritualism are dominant themes in movies and constitute a major model for explaining and interpreting mental illness in the movies and society. Furthermore, using the theory of social construction of reality (Berger and Luckmann 1966; Burr 1998; Collier 1998), African beliefs in magically explainable causes of mental illness have constituted a major model for explaining mental health. This is the truth as perceived by many; and represented in the media. Investigating if the media is responsible for the continued existence of such belief is another reason for further empirical inquiry. However, belief in magic and spiritualism as major underpinnings of interpreting causes and treatments of mental illness among Africans have cultural and historical values, which impact on

the knowledge of reality as conceived by members of the social group.

10.2 COMMUNICATING MENTAL HEALTH ISSUES IN FILMS

This study has shown that movie producers are concerned with producing commercially viable media products that will interest targeted audiences (Henderson 1996; Mosco 1996; Morris 2006). The need to produce sellable media messages impact on decisions made on ways mental health issues are constructed and presented in narratives. More on the importance of selling madness can be found in the third chapter. In this study, frames of mental health in narratives project mental health issues as social problems psychiatry cannot resolve alone. In the overall framings of mental health in the movies, cultural based beliefs (magic or spiritualism) were given salience over psychiatry, while predominant mental health options of treatment were largely magical, traditional or spiritual. Thus, this study opines that cultural acceptance of alternative options of mental health care over psychiatry in Nigeria exists (Heaton 2013c). The predominance of alternative mental health beliefs may be a fall out of psychiatric based stigma (Corrigan *et al.* 2001;

Angermeyer *et al.* 2005; Jorm and Oh 2009; Corrigan and Shapiro 2010; Sickel *et al.* 2014). More on social and cultural manifestations of stigma can be found in the fifth chapter of this study.

Conversely, tirades of meanings may be evoked if experientially, in an alternate culture, vagrancy and unkempt appearances symbolise the presence of lack of means other than mental illness. Within such cultures, the interpretation of a vagrant and unkempt individual would be based on physical experiences of such images and what they are known to represent. In this context, Coëgnarts and Kravanja (2012) argued that such interpretations fit into the theory of image schema, which involves concrete interpretation of images by tapping into a wide range of experiences that are grounded in daily physical interactions with the world. It is in the context of diverse cultural manifestations of stigma; bad and mad theory; and dominance of alternative mental health modes that this study supports the view that social and movie representations shape and are shaped by the culture of a particular society (cultural psychology) (Burr; Wig 1999; Rashed 2013).

10.3 CULTURAL IMPLICATION OF MEDIATED MADNESS

The notion that media messages construct social realities has been explained in Chapter Six. Examining perceptions held by movie producers and psychiatrists showed that messages in the media are reflections of popular mental health beliefs. It was observed that science-based mental health care professionals criticised media portrayals of mental health that adopt non-scientific causal and treatment explanations. Although, perceptions of content producers and narratives produced with mental health themes reflected causal and treatment options from scientific and alternative views, science based health care providers hold fervently to views that imply that mental health issues are better explained from the scientific point of view only. The result of this study confirmed earlier arguments that mental health across societies has deep cultural roots (Knapp *et al.* 2006).

Cultural, magical or religious beliefs about mental health are common in media depictions and popular perceptions of mental illness. Despite the emergence of psychiatry in Nigeria since 1950 (Heaton 2013a), cultural beliefs in magic or spiritualism persist as the major belief system around mental

health. The persistence of alternative beliefs in mental health has a high consequence for psychiatry. Continuous attempts at situating cultural beliefs in explanations of backward or unrealistic representations of mental health may result in a further decline in social acceptance of psychiatry in Nigeria (Gureje *et al.* 2005; Atilola and Olayiwola 2011). From emergent themes in this study, the option of integrating spiritualism and psychiatry in the resolution of mental health related issues (Wig 1999; Fernando 2007) was central to depictions of mental illness in movies; and perceptions held about mental health among movie producers.

The significance of spiritualism was highlighted in this study in the structuring of narratives. Spiritual, magical or traditional beliefs are evidently crucial to the way social issues are explained, understood and communicated among members of the Black culture (Chireau 1997). This claim was clearly supported by the prominence of magic and spiritual themes in the representation of mental health issues in movies and among movie producers in Nigeria. The popularity and significance of traditional, magical or spiritual beliefs in relation to mental illness among different cultural groups was explained in Chapter Four, a revelation that showed the importance of evoking magical beliefs in explaining social

phenomena to Africans. In other words, the growth of mental health in Nigeria may be reliant on the integration of some aspect of alternative mental health and psychiatry.

To reduce the present clash of ideology and interest between psychiatry and alternative modes of attending to mental illness in Nigeria, an integration of cultural beliefs and psychiatry in the explanations of causes and treatments of mental illness is suggested in this study. A move towards ethnocentrism or cultural imperialism in claiming the superiority of a causal or treatment modality over another will complicate the wide gap that already exist between alternative and science-based mental health care in Nigeria. The complication that emerges from the wide gap that exist between psychiatry and cultural beliefs in mental illness may lead to continued misconception, misinformation or misinterpretation of mental health issues in social and media spaces. In this case, the exclusion of supernaturalism/magic from lists of themes that negatively represent mental health is geared towards debunking earlier claims of poor knowledge of causes of mental health in Nigeria (Gureje *et al.* 2005). However, in this study, poor scientific diagnosis of mental illness was observed across the narratives: indicating poor

availability of information on psychiatry in movies and among movie producers.

The view held in this study is that knowledge of mental health cannot be considered poor when judged from the science-based knowledge of mental health only - although it has been argued that public confidence in psychiatry is low (Porter 2002). Cultural beliefs among members of a social group should constitute a socially approved knowledge base for evoking interpretations of mental health images. Therefore, further research is required to examine aspects of cultural beliefs in mental health that evoke positive or negative perceptions of mental health issues among Nigerians. The existence of negative representation of mental health in one society may represent positive perceptions of mental health in another society: a suggestion that perceptions of mental health will vary across cultures (Bhugra 2006). Invariably, the superiority of certain representations of mental health over others is dependent on culturally accepted; culturally nurtured; and predominant cultural beliefs that are held about mental health by members of a social group. In other words, differences in social perceptions of mental illness and science-based postulations of mental health exist and should be explored to

provide unified answers to questions that still fraught the existence of madness or mental illness in all societies.

10.4 PARAMETERS OF THE STUDY

There are quite a few limitations to this study. The investigation of mental health representations in ten movies using purposive sampling posed a challenge of possibly leaving out important materials for analysis. Movies selected were narratives on mental health themes produced between the year 2013 and 2014. A better sampling procedure would have been an extension of the number of years considered for selecting movies produced with mental health themes. A random or stratified selection of movies from an archive of mental health themed movies would have enhanced a generalizable sample selection process. However, the movies analysed in this study were selected from available movies with mental health themes on the internet; and in physical copies from movie shops. Movies produced in Nigeria are poorly preserved for future purchase at movie shops, partly because movie marketers are constantly churning out more movies into the market. This was a big challenge to this study.

A limitation in the selection of movies analysed exist in the restriction of movies to those produced in the Yoruba and English languages only. Nigeria is a multi-ethnic country with movies produced in English, Yoruba, Hausa, Igbo, and Bini languages (UNESCO Institute of Statistics [UIS]). Movies produced in other languages were not analysed in this study, making the conclusion specific to themes of mental health in movies produced only in Yoruba and English languages.

Thirdly, it is crucial to note that the limited number of interview respondents selected for this enquiry is a limitation to this study. The selection of three producers and three professional mental health care providers was not made from a list of producers or professionals representing the total number of producers and professionals in the country. The selection of movie producers was influenced largely by the researcher's perception of popularity ascribed to them. The selection of professionals in science based practise involved purposively selecting two psychologists and one neuro-psychiatrist from a major mental health care facility in Lagos (a south-western state in Nigeria). Science based professionals selected in the interview technique could have been selected from a distribution of occupational therapist, psychiatrist, pharmacist, nurses, and nutritionist that work

in mental institutions. Future research may by extension, include other science-based mental health care professions for a wider coverage of views held about media representations of mental health issues in Nigeria.

And lastly, analysis of audience perception of media representations of mental health was not included in this study. An audience study would have enhanced the corpus of studies on mediated mental health themes. Future studies will require a comprehensive audience study in order to investigate the effect mental health themes in movies have on the attitude or perceptions held about mental health issues.

APPENDIX A

CONSENT FORM

I have read the information sheet provided by the researcher named Khadijah Aroyewun – Adekomaiya from De Montfort University, Leicester.

I understand that the researcher will be using the outcome of my interview as data for her research.

I am aware that the content of the interview will be recorded for the purpose of transcription.

I agree to the analysis of the data from this transcription, for the purpose for which it is meant for.

I understand that the outcome of this research, including my involvement as a participant, will be presented in the PhD thesis and other academic presentations. However, I am aware that my professional status will be referred to, but my name and other personal information will only be used if I approve of its usage.

I am convinced that this research will abide strictly to set code of conducts and practice according to the ethical requirement of academic research and Data Protection Act.

By agreeing to partake in this research, I as the participant, give the researcher my full consent to use the content of the interview for the purpose for which this work is meant.

I understand that I have the right to take part or 'not' in this study. I do have a right to reject participation in this work without a valid reason as to why. I agree and understand that my informed consent is completely voluntary without any compulsion and/ or obligation.

After due consideration to all these, I agree with the following conditions (if there are other things you would want the researcher to put into consideration);

Signature:

Name:

Date:

Contact details:

APPENDIX B

INFORMATION SHEET.

Dear Participant,

This research is being taken in pursuit of a PhD in Media Discourse from De Montfort University.

This research seeks to do a Discourse analysis of content of some fictional Nigerian movies and how the emotive, textual and thematic characteristics of these movies are capable of influencing attitude change in viewers towards mental health care.

This study will do a voice recording of the interview that will be conducted with you in order for proper transcription of the interview, which will also be analysed for the purpose of this work.

This work will abide strictly to the ethical requirement of the Data Protection Act, 1998 and the British Sociological Association's Statement of Ethical Practice (March, 2002).

Your right to confidentiality and non- disclosure of identity (such as name, photographs, address etc.) will be respected and honoured.

Your participation in this research implies that you have given your consent to use the data accrued from this interview for the purpose of this work.

Your involvement is in the form of answering questions put to you by the researcher and you have the exclusive right to answer or ignore any question without been pressurized to do otherwise.

You are under no compulsion to partake in this exercise. Your participation is entirely voluntary and withdrawal is allowed at any stage of this research without fear of reprisal or repercussions.

Thank you for contributing to the success of this work as your participation is highly appreciated.

Researcher: Khadijah Aroyewun – Adekomaiya,
ummumhammadkhadijat@yahoo.com

Director Of Study: Stuart Price, sprice@dmu.ac.uk

APPENDIX C

CODING SHEET FOR CONTENT ANALYSING MOVIES

TABLE 1: FRAMES OF MENTAL ILLNESS				
CODES	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
CATEGORY ONE: Basic descriptors of the mentally ill.				
Gender	Male - 1	5	13	38.50%
	Female - 2	8	13	61.50%
Social status	Level of education indicated (educated or not educated) -1	6	13	46%
	Level of education Not indicated - 4	7	13	53.80%
	Educated			23.00%
	Not educated			23.00%
Disability status	Disabled -2	NIL	13	0%
	Physically abled -3	13	13	100%
Economic status	Employed - 1		Nil	0%
	Unemployed - 2	10	13	76.90%
	Not indicated - 3	3	13	23.10%
Role of character	Lead role - 1	5	13	38.40%
	Supporting role - 2	4	13	30.80%
	Mini role - 3	4	13	30.80%
Presented symptoms of mental illness	Over elation - 1	9	13	69.00%
	Suicidal ideation - 2	1	13	7.70%
	Aggression - 3	6	13	46.20%
	Vagrancy - 4	12	13	92.30%
				7.70%
CATEGORY ONE: Basic descriptors of the mentally ill.	Low mood – 5	1	13	
	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE

	Hallucination - 6	2	13	15.40%
	Incoherence in speech / action - 7	8	13	61.50%
	Regressed behavior - 8	9	13	69.00%
	Hysteria - 9	6	13	46.20%
	Unkempt appearance - 10	11	13	84.60%
	Defiant behavior - 11	NIL	13	0%
	Mental Retardation - 12	NIL	13	0%
	Hoarding - 13	5	13	38.40%
	Delusion - 14	8	13	61.50%
	Others - 15	NIL	13	0%
CATEGORY TWO: Causes of mental illness.	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Alternative (Traditional / Magical / Religious causes)	Possession by demons - 1	NIL	13	0%
	Magical spell / incantation - 2	8	13	61.50%
	God's will - 3	NIL	13	0%
	Not indicated - 4	5	13	38.40%
Scientific causes	Substance abuse - 1	NIL	13	0%
	Psychosocial / economic factors - 2	2	13	15.40%
	Biological / neurological - 3	NIL	13	0%
	Not indicated - 4	611	13	84.60%
CATEGORY THREE: Treatment Modality	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Science based treatment	Visit to general practitioners - 1	3	13	23.10%
	Use of medication - 2	3	13	23.10%
	Psychiatric intervention - 3	1	13	8%
	Asylums / mental institutions - 4	2	13	15.40%
	home / community based - 5	1	13	7.70%
	Not indicated - 6	7	13	53.85%
Alternative	Counselling - 1	NIL	13	0%
	Use of herbs - 2	1	13	7.70%

	Exorcism - 3	NIL	13	0%
	Incantation / Prayers - 4	4	13	30.77%
	Magical objects - 5	3	13	23.10%
	Centers for alternative practice - 6	1	13	7.70%
	Not indicated - 7	5	13	38.40%
CATEGORY FOUR: Stereotypic portrayal	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Recovery status	Full recovery (presence of social reintegration) - 1	7	13	53.85%
	Partial recovery (absence of social reintegration) - 2	1	13	7.70%
	Persistence of the disorder - 3	3	13	23.10%
	Progressive deterioration - 4	NIL	13	0%
	Not indicated - 5	5	13	38.40%
CATEGORY FOUR: Stereotypic portrayal	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Full Recovery	From Scientific intervention - 1	3	13	23.10%
	From Alternative intervention - 2	4	13	30.77%
	Not indicated	7	13	53.85%
Partial Recovery	From Scientific intervention - 1	1	13	7.70%
	From Alternative intervention - 2	NIL	13	0%
	Not indicated - 3	12	13	92.30%
CATEGORY FIVE: Stigmatic representation	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Violence towards the mentally ill	Physical assault - 1	4	13	30.77%
	Name calling - 2	2	13	15.40%
	Economic / social depravation - 3	NIL	13	0%
	Sexual abuse - 4	1	13	8%
	Not indicated - 5	8	13	61.50%

Violence towards self	Suicidal ideation - 1	1	13	7.70%
	Self harm - 2	1	13	7.70%
	Not indicated - 3	11	13	84.60%
CATEGORY FIVE: Stigmatic representation	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Violence From The Mentally Ill Towards Others (Provoked)	Physical assault - 1	5	13	38.40%
	Verbal assault - 2	1	13	7.70%
	Sexual abuse - 3	NIL	13	0%
	Murder - 4	NIL	13	0%
	Not indicated - 5	8	13	61.54%
Violence From The Mentally Ill Towards Others (Non Provoked)	Physical assault - 1	5	13	38.50%
	Verbal assault - 2	NIL	13	0%
	Sexual abuse - 3	NIL	13	0%
	Murder - 4	NIL	13	0%
	Not indicated - 5	8	13	61.50%
Exploitation of the mentally ill	Economic - 1	NIL	13	0%
	Sexual - 2	2	13	15.40%
	Not indicated - 3	11	13	84.60%
Control measures used for the mentally ill	Restraint - 1	3	13	23.10%
	Physical assault (beating, insults, verbal threats) - 2	1	13	7.69%
	Persuasion - 3	6	13	46.20%
	Not indicated - 4	3	13	23.10%

CATEGORY FIVE: Stigmatic representation	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Mental illness as means to an end	Magical harm on others - 1	4	13	30.70%
	Magical favour to others - 2	3	13	23.10%
	Not indicated - 3	6	13	46.20%
Other important portrayed feature of the mentally ill	Friendly -1	NIL	13	0%
	Calm: Subtle display of mental illness - 2	3	13	23.10%
	Cooperative (willingness to get better) - 3	1	13	7.70%
	Blameworthy - 4	3	13	23.10%
	Benevolence - 5	3	13	23.10%
	Others - 6	8	13	61.50%
Reaction of others towards the mentally ill	Pity - 1	3	13	23.10%
	Anger - 2	2	13	15.40%
	Disgust (cognitive)- 3	2	13	15.40%
	Severance of Ties - 5	NIL	13	0%
	Acceptance/ Compassion/ Care -6	7	13	53.85%
	Social /Economic depravation - 7	NIL	13	0%
	Soft target - 8	2	13	15%
	Reproach (behavioural) - 9	7	13	53.85%
	Fear - 11	6	13	46.20%
	Not Indicated - 10	1	13	7.70%
CATEGORY FIVE: Stigmatic representation	UNITS OF ANALYSIS	FREQUENCY	TOTAL OF POSSIBILITIES	PERCENTAGE
Impact of dealing with the mentally ill on social members (families and friends)	Acceptance / Care - 1	2	13	15.40%
	Emotional Distress - 2	6	13	46.20%
	Economic / Financial	NIL	13	0%

	Difficulty - 3			
	Social Castigation - 4	NIL	13	0%

APPENDIX D

FILMOGRAPHY: LIST OF MOVIES ANALYSED AND URL ADDRESS

BASIC DESCRIPTORS OF MOVIES									
MOVIE TITLE	URL ADDRESSES	ST AT US	DA TE VI EW ED	NO. OF MENTAL LY ILL CHARAC TERS	LAN GU AGE	PUB LISH ING DAT E	VIE WI NG TI ME	INTERNET VIEWERSH IP	
<i>ORE META WERE KAN</i> (THREE FRIENDS AND ONE MAD PERSON) - 2	https://www.youtube.com/watch?v=KxpBNOUhH-c	M OV IE 1	22 /0 5/ 20 16	1	Yor uba	2014		110, 959	
<i>EGWONGA</i> (THE DEADLY GOD) - 2	https://www.youtube.com/watch?v=jmsKdgcr5s	M OV IE 2	23 /0 5/ 20 16	1	Engl ish	2014		20,9 36	
<i>ASO WERE</i> (MAD MAN'S CLOTH) - 1	https://www.youtube.com/watch?v=w5Ef1XLJ7EA	M OV IE 3	24 /0 5/ 20 16	1	Yor uba	2013		135, 969	
<i>OBIRIPO</i> (WHAT GOES AROUND COMES AROUND) - 1 & 2	https://www.youtube.com/watch?v=D5GFrc79PEI	M OV IE 4	24 /0 5/ 20 16	2	Yor uba	2014		79,1 09	
TEARS OF MADNESS - 1		M OV IE 6	24 /0 5/ 20 16	1	Engl ish	2013		NA	VC D
TEARS OF MADNESS - 2	https://www.youtube.com/watch?v=06VRIKyN99k	M OV IE 5	25 /0 5/ 20 16	1	Engl ish	2013		107, 123	
<i>ELULU</i> - 1	https://www.youtube.com/watch?v=uMiZHQsAW48	M OV IE 7	25 /0 5/ 20 16	2	Yor uba	2014		2,58 7	REP UB LIS HE D
<i>ELULU</i> - 2	https://www.youtube.com/watch?v=5ZH1s5bIH9o	M OV IE 8	26 /0 5/ 20 16	1	Yor uba	2014		3,62 4	REP UB LIS HE D
MAD COUPLE	https://www.youtube.com/	M OV	26 /0	1	Engl ish	2014		10,7 37	REP UB

	watch?v=I59vBE3_7i8	IE 9	5/ 20 16						LIS HE D
IRE AJE	https://www.youtube.com/watch?v=7AedbNEO6no	M OV IE 10	26 /0 5/ 20 16	2	Yor uba	2014		10,7 45	

APPENDIX E

CATEGORIES AND CODES FOR ANALYSING MENTAL HEALTH THEMES IN MOVIES

1. Category:- BASIC DESCRIPTORS

Sub Category 1:- DESCRIPTORS OF MOVIES

Code: MOVIE TITLE

Code: RUNNING TIME

Code: BOX PERFORMANCE

Code: LANGUAGE

Code: BASIC PLOT

Code: GENRE

Code: INTERNET VIEWERSHIP

Sub Category 2: DESCRIPTORS OF MENTALLY ILL CHARACTER(s)

Code: GENDER - **Sub Code:** MALE and FEMALE

Code: SOCIAL STATUS - **Sub Code:** LEVEL OF EDUCATION, DISABLED, PHYSICALLY ABLED, NOT INDICATED

Code: ECONOMIC STATUS **Sub Code:** EMPLOYED, UNEMPLOYED, DEPENDENT ON OTHERS FOR LIVELIHOOD, NOT INDICATED

Code: ROLE OF THE MENTALLY ILL - **Sub Code:** LEAD ROLE, SUPPORTING ROLE, MINI ROLE

Code: PORTRAYED SYMPTOMS OF THE MENTALLY ILL

Sub Code: OVER ELATION,

Sub Code: SUICIDAL IDEATION

Sub Code: AGGRESSION

Sub Code: VAGRANCY

Sub Code: HOARDING

Sub Code: LOW MOOD

Sub Code: HALLUCINATION

Sub Code: DELUSION

Sub Code: INCOHERENCE IN SPEECH OR ACTION

Sub Code: REGRESSED BEHAVIOUR (infantile behaviour, eating food from a dump area, drinking urine, immoral activity etc.)

Sub Code: SUBSTANCE ABUSE

Sub Code: HYSTERIA

Sub Code: UNKEMPT APPEARANCE

Sub Code: DEFIANT BEHAVIOUR

Sub Code: MENTAL RETARDATION

2. **Category:** PORTRAYED CAUSES

Sub Category 1: ALTERNATIVE (Traditional and Religious) CAUSES

Code: POSSESSION BY DEMONS

Code: MAGIC SPELLS (Enchantment/ Use Of Charms or Herbs/ Witchcraft)

Code: GOD'S WILL

Code: NOT INDICATED

Sub Category 2: SCIENTIFIC CAUSES

Code: SUBSTANCE ABUSE

Code: PSYCHO-SOCIAL (Environmental & Economic Factors)

Code: BIOLOGICAL CAUSES (brain disease, heredity)

Code: NOT INDICATED

3. **Category:-** PRESCRIPTION FOR TREATMENT

Sub Category 1: SCIENCE BASED TREATMENT

Code: VISIT TO GENERAL PRACTITIONERS

Code: USE OF MEDICATION

Code: PSYCHIATRIC INTERVENTION

Code: ASYLUMS / MENTAL INSTITUTIONS

Code: HOME / COMMUNITY BASED TREATMENTS

Code: NOT INDICATED

Sub Category 2: ALTERNATIVE (religious or traditional) TREATMENT

Code: COUNSELLING (when it is carried out by adherents of various religious belief outside of the science based psychotherapy)

Code: USE OF HERBS

Code: EXORCISM

Code: INCANTATION AND / OR PRAYERS (Islamic or Christianity)

Code: MAGICAL OBJECTS / CHARMS / HOLY SUBSTANCES

Code: CENTRES FOR ALTERNATIVE PRACTICE (religious or traditional)

Code: OTHERS

4. **Category:** STEREOTYPICAL PORTRAYAL

Sub Category 1: RECOVERY STATUS

POSITIVE: Code: FULL RECOVERY (complete cure)

Code: PARTIAL RECOVERY (complete remission with risk of relapse, partial remission with risk of relapse)

NEGATIVE: Code: PERSISTENCE OF THE DISORDER

Code: PROGRESSIVE DETERIORATION

Code: NOT INDICATED

Sub Category 2: FULL RECOVERY

POSITIVE: Code: FROM SCIENTIFIC INTERVENTION

Code: FROM ALTERNATIVE (Traditional and Religious) INTERVENTION

NEGATIVE: Code: NOT INDICATED

Sub Category 3: PARTIAL RECOVERY

POSITIVE: Code: FROM SCIENTIFIC INTERVENTION

Code: FROM ALTERNATIVE (Traditional / Religious) INTERVENTION

NEGATIVE: Code: NOT INDICATED

5. **Category:** STIGMATIC REPRESENTATION –

Sub category 1: VIOLENCE TOWARDS THE MENTALLY ILL

POSITIVE: Code: NOT INDICATED

NEGATIVE: Code: PHYSICAL ASSAULT (mild or extreme)

Code: NAME CALLING

Code: ECONOMIC / SOCIAL DEPRAVATION

Code: SEXUAL ABUSE

Sub Category 2: VIOLENCE TOWARDS SELF

POSITIVE: Code: NOT INDICATED

NEGATIVE: Code: SUICIDAL IDEATION

Code: SELF HARM (cutting or actions aimed at causing injury only the body)

Sub Category 3: VIOLENCE FROM THE MENTALLY ILL TOWARDS OTHERS (PROVOKED)

POSITIVE: Code: NOT INDICATED

NEGATIVE: Code: PHYSICAL ASSAULT

Code: VERBAL ASSAULT

Code: MURDER

Code: SEXUAL ABUSE

Sub Category 4: VIOLENCE FROM THE MENTALLY ILL TOWARDS OTHERS (UNPROVOKED)

POSITIVE: Code: NOT INDICATED

NEGATIVE: Code: PHYSICAL ASSAULT

Code: VERBAL ASSAULT

Code: MURDER

Code: SEXUAL ABUSE

Sub Category 5: EXPLOITATION OF THE MENTALLY ILL

POSITIVE: **Code:** NOT INDICATED

NEGATIVE: **Code:** ECONOMICAL

Code: SEXUAL

Sub Category 6: CONTROL MEASURES USED FOR THE MENTALLY ILL

POSITIVE: **Code:** PERSUASION

Code: NOT INDICATED

NEGATIVE: **Code:** RESTRAINT

Code: PHYSICAL ASSAULT (beating, insults, verbal threats)

Sub Category 7: MENTAL ILLNESS AS MEANS TO AN END

POSITIVE: **Code:** NOT INDICATED

Code: MAGICAL FAVOUR TO OTHERS

NEGATIVE: **Code:** MAGICAL HARM ON OTHERS

Sub Category 5: OTHER IMPORTANT PORTRAYED FEATURE OF THE MENTALLY ILL

POSITIVE: **Code:** FRIENDLY (willingness to help others)

Code: CALM (subtle display of mental illness)

Code: COOPERATIVE (willingness to get better)

NEGATIVE: **Code:** BLAMEWORTHY (they are to blame for their mental illness)

Code: BENEVOLENCE (people with mental illnesses are childlike and innocent)

Sub Category 8: REACTION OF OTHERS TOWARDS THE MENTALLY ILL

POSITIVE: **Code:** PITY

Code: ACCEPTANCE (compassion/ care)

Code: NOT INDICATED

NEGATIVE: **Code:** ANGER / FRUSTRATION

Code: DISGUST (cognitive)

Code: REPROACH (behavioural)

Code: BLAME

Code: SEVERANCE OF TIES

Code: SOCIAL / ECONOMIC DEPRAVATION

Code: NOT INDICATED

Sub Category 9: IMPACT OF DEALING WITH THE MENTALLY ILL ON SOCIAL MEMBERS (FAMILIES AND FRIENDS)

POSITIVE: **Code:** ACCEPTANCE / CARE

NEGATIVE: **Code:** EMOTIONAL DISTRESS

Code: ECONOMIC / FINANCIAL DIFFICULTY

Code: SOCIAL CASTIGATION

Code: NOT INDICATED

6. **Category:** NARRATIVE FORM

Sub Category 1: NARRATION ELEMENTS

Code: NON CHRONOLOGICAL

Code: FLASH BACK

Code: DREAMS

Code: FLASH FORWARDS

Code: OPEN STRUCTURE

Code: CLOSED STRUCTURE

Code: CHRONOLOGICAL

Code: MULTI – STRANDED

Code: POINT OF VIEW

Code: PREVIEW

Sub Category 2: NARRATIVE STRUCTURE

Code: INTRODUCTION

Code: DISRUPTION

Code: RECOGNITION

Code: RESOLUTION/ ATTEMPT TO REPAIR

Code: NEW EQUILIBRUM / STABILITY

Sub Category 3: OTHER NARRATIVE ELEMENT

Code: THE HERO

Code: THE VILLIAN

Code: THE HELPER

Code: THE REWARD

Code: THE VICTIM

Code: THE FALSE HERO

APPENDIX F

TRANSCRIPT OF THE INTERVIEW: PSY ONE

Question 1: Thank you so much for being a part of this interview/ process towards acquiring a PhD from De Montfort University, Leicester. My name is Khadijah Aroyewun – Adekomaiya. Please, kindly tell me who you are.

Interviewed: My name is ... I am a clinical psychologist here at the Federal Neuro-Psychiatric Hospital, Yaba.

Question 2: I want to ask you about what you do as a clinical psychologist.

Interviewed: As a clinical psychologist in this hospital, what I do mainly include assessment basically psychotherapy teaching as well.

Question 3: When you say teaching, how do you mean Sir?

Interviewed: Teaching, we also have well this hospital is also a centre for post graduate training of other mental health experts including psychiatrists, psychiatric nurses and occupational therapist and I also teach other people including clinical psychology interns.

Question 4: To start with, I am going to be using some terminologies. Pardon me if I don't capture all the things that have to do with psychotherapy as it were. When I use orthodox or professional medical mental health care I mean coming to the hospital and visiting professionals like yourself and when I refer to the traditional means of seeking health care, I mean the conventional Nigerian style of going to the church, going to the mosque or going to the traditional medical health care providers i.e. the "supposed" medical mental health care providers.

Interviewed: I understand!

Question 5: To start with, my topic is to look at the role the media is playing in influencing the attitude of Nigerians towards seeking professional psychological treatment. So going forward, are information about orthodox / professional medical mental illness readily available to Nigerians? Would you say in your on view, Nigerians have access to enough information about professional medical treatment?

Interviewed: Well, I don't think we have enough information about orthodox health when it comes to mental health. We don't have enough.

Question 6: How can you tell?

Interviewed: I can tell because quite a lot of people out there have most of these psychological conditions that we see that they complain of but one way or the other they don't know what they do. They just go around with the condition and with the illness. So they don't seek help because they don't know what is happening to them, including things as obvious as seizure disorders. Some will just believe that it is another thing entirely. That it is an attack from the gods or something like that. Depression is the worst culprits. Most people with depressive symptoms will treat entirely other things totally; they will treat typhoid fever, they will treat malaria. They

will treat all sorts of things. They will treat so many things that are symptoms of depression, but it is actually difficult for them to seek help for the condition.

Question 7: You actually mentioned depression. One of the evolving themes that I will be looking at in the print media involves keywords with ADHD, autism, schizophrenia plus depression. How much would you say Nigerians know about this other form of mental illness?

Interviewed: Perhaps, maybe in descending order, the awareness for some conditions, for some psychological or mental health problems is increasing, especially children. There appear to be some groups that are non – governmental now, that take up that challenge especially when it comes to ADHD and autism. There is quite a lot of media work going on you know things like ADHD, there are non – governmental groups now that are championing the awareness. So, but for other conditions like schizophrenia and depression, information is not as much. This hospital has a Hospital Community Outreach that attempts to go out to the market, schools and other public places to educate people provide awareness about these conditions and to rasp up people’s knowledge. This is just to tell you that it is still not adequate. We know that we are not capturing all, well, the vital part of the population.

Question 8: How much is the Hospital Community outreach doing? What are the methods that they have employed?

Interviewed: Basically, we use talks, drama. It’s a group, a committee of this hospital of which I am a member as well. We go out, give people health talks like sort of a psycho - education telling people about symptoms of and that if they notice any of the symptoms they could reach out and come to this hospital for help. You know, we also use other media like drama, I think that is basically all, health talk and drama.

Question 9: Do you make use of the newspapers, the television, and the movies?

Interviewed: Individually, some members and other staff of the hospital are invited to other radio programs, television programs, and some also have write-ups in the newspaper just to actually convey and pass on the message about the good method and some specific method.

Question 10: Thank you Sir. From your experience, what is the first contact for mental health care among visiting patients?

Interviewed: Basically, it is spiritual either the pastor or the Islamic cleric.

Question 11: Other than the pastor or the Islamic cleric, do they visit the other options?

Interviewed: Yeah, for most people, the pathway to assessing orthodox mental health care usually starts from basically they discuss within the family, that’s the first thing. Maybe, somebody observed certain thing, the husband observed certain things in the wife and the wife observed certain things in the husband or maybe the children, they discuss within the family, get suggestion, ok, ‘let’s see “*Alagba*” or the pastor or the Islamic cleric to discuss with those people. At times, we have relief of symptom basically because you are talking about it and because of the nature of some of these illnesses. It comes like types like that. If they are not satisfied with it, they might consider traditional medical practitioner as another option where they will also go. Of

course, we know what that one involves. Quite a lot of things are admitted in some churches also and some other homes including the spiritual could also admit and you know “treat” and of course if they are not satisfied with the spiritual and the traditional healer to spend some time there, if they are okay, if they are not okay, this place is the last option most of the time for most of the people that I see. Yes they are getting a recent flurry of people who chose this place as the first option but they are very, very minimal. I don’t want to give a percentage but about 5% of the case.

Question 12: Have you had the opportunity of asking these people how they chose and decided to come here first rather than adopt those other form of healing and prevalent options?

Interviewed: Some of them might have just stumbled on some of our outreach programs or maybe they listened to some of the program our people did on radio or maybe contact through a friend, then, web search.

Question 13: When did orthodox/ professional medical means of curing mental illnesses began to take shape in this country Nigeria? I don’t know if since time immemorial orthodox means of healing the mentally ill has always been available. When did the orthodox means come to the fore?

Interviewed: If we look at it historically, I think the first mental based hospital or mental home as it was then called was established in 1904 that was in Calabar. That is the first one; this particular centre i.e. (Federal Neuro – Psychiatric Hospital, Yaba) was actually established in 1907. So, we have about 110 years or thereabout history of orthodox mental health care. And what was done basically that time was just custodial. It was like a mental asylum, where to keep lunatics as they were called then off from public view. So, that is the service that was provided at that time. Just to keep them somewhere. There was no doctor, no nurse but just put in custody to prevent them from moving around the street and “not to constitute nuisance” until about in the fifties or thereabout, especially here when we now began to have the first set of doctors. The focus started changing from custodian to care. The first set of health providers were been trained, doctors and nurses were sent to London, then they came back and then became the superintendent. So apart from taking charge of the inmates as they were called then, they were also providing some little care. So that one will start about in the fifties. So the first set of doctors started coming about in the late fifties to sixties. I think the first psychiatrist then, Lambo came on board. I am not too sure now maybe in the early sixties and late fifties. A lot of them came back to Nigeria and started practicing. That is how it has been. So gradually and gradually, so we are talking about roughly fifty to sixty years. It is as recent as that.

Question 14: Is the orthodox / professional medical treatment style likely to completely replace the traditional means through the media? Considering what you have said that most of the people that have come to the hospital at the first onset of mental illness do so basically because they have had access to your programs through the various media. Would you say that if the media could be a source of eradicating complete allegiance to the old and traditional healing system?

Interviewed: Well, there will be increased allegiance, I would say because really we are Africans and the Africans are still quite a lot spiritually inclined. We still have these believes even the most spiritually inclined will still have part of the family members who will still want to influence towards that believe. Maybe in terms of

improving the presentation of this hospital, the media has actually a lot of important role to play. We have regular slots that day in day out, on daily basis or maybe at a particular time, if we have regular slots that are being used or reserved for mental health issues, perhaps things will improve, especially from prominent media houses. I want to believe that this could actually bring about a difference for those who can read anyway.

Question 15: What would you consider in our society today your impression of the depiction of the mentally ill in our movies? Let's start with the movies first. How do you feel as a professional?

Interviewed: I think the way the mentally ill are being depicted in the movies is still archaic. The presentation as in the movies is derogatory. I think archaic is the word. The movies are an emphasis or an exaggeration of psychotic distress that is meant to amuse basically. It is an exaggeration of a person who is supposed to be in psychotic distress: you see somebody scratching himself, behaving abnormally right there in the public, tearing clothes, looking tattered and rugged, killing, wanting to kill, crushing, breaking and someone people are running away from, living in dilapidated buildings, living in uncompleted buildings, being sexually molested, abused and raped by 'ritualists' and all stuffs. That is the depiction of the mentally ill and the picture in the media. It is also stigmatizing; oh you shouldn't move close to him, you shouldn't help him, just stay away from him. They belong to the bush. That is the idea that with mentally ill, it does not have anything to do with this within a regular home. That is the picture I have about the depiction of the mentally ill in the movies.

Question 16: How about the depiction in the newspapers?

Interviewed: The newspaper is much more, well, a little bit enlightening although anytime you want to see a picture or they want to refer to a mentally ill. The picture you also see is especially similar. They will choose somebody who is and looking very dishevelled and roughly dressed. That is the picture. And I want to believe that this is still the impression that most Nigerians have about people who are mentally ill. It will constitute the attitude generally towards the mentally ill people, that they are out of this world ... like they are from the wild and should be left in the wild. That is the general picture.

Question 17: On our streets you actually see a whole lot of people looking dishevelled and tattered and completely dirty and obviously they sleep under the bridges. So would we blame the media for making us interpret them as mentally ill people or they are truly mentally ill people who wear this garb of dirty looking, dishevelled persons?

Interviewed: Khadijat, (name of interviewer) funny enough most of the people you are referring to are not actually regarded as mentally ill. Our society has a name for them, created a new name for them; 'area boys' and 'girls' to separate them from the mentally ill. This is just telling you more about stigmatization. Those people are more stigmatized than the so called area boys who also will most likely have a symptom of mental illness or the other but because..

Question 18: Why would you say that?

Interviewed: Why I would say that is that we understand the nature of anybody who is living in such manner is described might have one or two challenges concerning

mental health. In our study, I stand to be corrected, they usually are. But a man whose hair is dishevelled, is probably walking naked and stuff is now totally assigned more stigma than that person who perhaps is just “hustling” to buy the next fix of drugs. Most of the people we call the area boys are actually drug addicts so that is one of the way we know that they have mental health issues.

Question 19: There was this day I was returning from work and I saw this woman who all of a sudden started dancing in the public eye. She started removing her wrapper and I looked around there was no camera and obviously she sharply passed by me and I was like Oh My God, is everything alright. All of a sudden I saw her dancing and these are the kind of things you see in the movies too. What can you say about that?

Interviewed: Well, that’s real. I think psychotic distress can occur at any time. But remember it will have been building up but because of lack of awareness he doesn’t know what to do. So the person could break down at any time and at anywhere even during a ceremony. You know when it reaches the peak that is when the person breaks down. Perhaps the one you are referring to as reached the peak at that particular time and perhaps the person was acting from a hidden camera, you don’t know. But that really happened; the key thing is that it may happen due to the psychotic experience she was going through at that time. But what is the next thing to do that is what we should look at. An aware society will quickly rush in to assist. So that is what we are talking about. But the kind of psychotic distress she is in is similar to somebody who has been hit by a car, who will be rolling on the floor in pain, in distress; because that one is going through physical distress, this one is going through mental distress. So she also requires assistance. She is unaware of what is happening to her. So she requires as much assistance as the one who has been knocked down by a car. Anywhere, *Lagosians* don’t also respond to people who are knocked down by cars anyway, maybe that is another case study.

Question 20: As a professional working with other professionals as a member of the Hospital Community Outreach, have you worked with media content producers in order to influence the healing method they adopt in the movies?

Interviewed: Yes, the scenario you actually talked about happen very seldom. Yes, I am aware that at some point, producers have actually approached some of our members to discuss the process and to understand more about mental illness as well as discuss the process of treatment. But it’s not enough. If there are about a hundred movies, we have not had a study yet but maybe out of every hundred movies, maybe two or one from my opinion will approach the hospital for information.

Question 21: What would you say of the synonymous representation of murder crimes with mental illness as usually claimed by suspects such as the case of the Paralympics athlete who seem to be laying claims to mental illness for murdering his girlfriend, as presented in the newspaper?

Interviewed: I think the most important thing is that mental illness can happen to anybody and then there are so many types of mental illness that most people are not aware of. Most people’s knowledge about mental illness and symptoms of mental illness revolve around about five or six or eight symptoms. Dishevelled hair, tattered clothes, unusual behaviour, walking around nude, some aggressive behaviour, you know things like that. These are the very commonest symptoms people are familiar

with. But there are some other but also more dilapidating symptoms that may affect people. And perhaps that is why most of the people do not even see them because people do not know that these symptoms are there and that they are actually experiencing some symptoms of mental illness. For people who usually seek mental health to cover after a crime; I won't say they are seeking that, what If that is the case? It is for the psychologist now, or the mental health expert who carries series of assessment if these were so, because really it may be so. Apart from the Pistorious case which; I believe is the one you are referring to, so many other ones even here in Nigeria, it has happened. That is why I said a lot of people have this condition and most people don't know. All they know is that this person is somehow, she is this she is that, whereas the person is undergoing major psychiatric illness that could actually involve things like murder and stuffs like that. And there are several cases like that, maybe murder, abduction; it could be a form of mental illness that could be responsible for all these things. We have quite a lot of them presented to us here. The police and the court will refer to us. The referral for that is actually increasing now. I want to believe there are some elements of mental issues in most criminal behaviour.

Question 22: Would you say the media represent undistorted perception about mental illness for example the movies. Would you say what they have in the movies is just a mirror making of what we have among Nigerians?

Interviewed: I believe so. Like I mentioned it earlier like what they are depicting in the media, movies are supposed to depict the mind of the population. I believe that the way the movies depict mental illness is the way the society see of mentally ill people.

Question 23: What can the newspaper and the movies do to effect positive or negative perception about professional mental health care.

Interviewed: By giving out the right information. By giving out the quiet symptoms that most people actually carry around without knowing that they are actually symptoms of mental illnesses. Then, by educating on what to do in the case of distress. No.1; preventive, by giving information on the symptoms as much, if not all the symptoms mental illness in various types and kinds and everything on how to prevent mental illness. How to live a good life, to be able to monitor one's own capacity, not to stress yourself and stuffs like that. How to use alcohol moderately and stuffs like that if they are going to use it at all. Things like that; how to live a life with reduced stress in order to reduce the occurrence of mental illness. And of course, when we now have any form of mental illness, the right thing to do, the steps to take, where to go, what to do like a form of first aid and the next place or the next thing to do. I think that is the major role they (the media) can actually play.

Question 24: Do you consider the media playing any negative role?

Interviewed: Maybe, they should try to extinguish the negative views.

Question 25: What do you mean when you say negative views?

Interviewed: I know that the media try to pick what the society believes about mental illness. They can use that knowledge to serve the public with the right conception of what mental illness is all about and what to do about it instead of flowing or going with the society's view.

Question 26: Would you say that the content of the media i.e. the movies, have any impact on the individuals who avail themselves of their use. For example, have you had a case where have come and said that I deliberately went to the cleric first basically because of what they saw on television. Do people actually behave the way they o simply because they saw it on television?

Interviewed: I may not be able to say because I have not had that kind of experience with a patient before, but I know that the media can actually influence both the attitude and behaviour, especially behaviour. I know that. So if they (the media) can do that, so if they give information by depicting the mentally ill that way, the viewer may be convinced that that is actually the right way to tackle it, if the media continues to portray it that way, they might think that is the right thing to do.

Question 27: And how about the newspapers?

Interviewed: Similar

Question 28: Some research results have revealed that Nigerian movies eulogize diabolic, fetish reasons and causes of mental illness, does this impact on the behaviour of people with mental illness?

Interviewed: My own personal contact has revealed that for some categories of people, if you give them certain information especially about symptoms of certain conditions of some mental illness or anything, it will appear as if this illness will begin to manifest. Whether you are giving orthodox psycho – education or they are watching a particular movie. It might appear as if it is there, though we know that that is not so, yes it is most likely. There is that possibility. That is why some movies will carry information of instruction to warn them ahead on what will happen for example scenes that could trigger epileptic activity, they would have forewarned initially so that people who believe they are susceptible to that kind of scenes would not be watching that movie. Similarly, some movies can contain content that may stimulate that kind of behaviour and they might warn initially the public about that.

Question 29: Can the present depiction of mental illness in the media i.e. in our Nollywood movies and in the newspaper be said to be a reflection of what is obtainable and entrenched in the society.

Interviewed: Yes

Question 30: Would you assert that?

Interviewed: Oh yes, I will definitely assert that.

Question 31: In your view, how much do people know of the causes of mental illnesses? How much can the media do to impact on the present situation?

Interviewed: The public knows a little. I can't give a percentage but I can say that one over four i.e. about twenty five percent. Information is probably restricted to people whose educational level is a little bit higher, than the primary school, and maybe secondary school will be in that category of 25%. Most people who have educational that is below primary education, perhaps we are talking about single digit. Between five to nine percent of them might begin to think maybe it is an orthodox related condition. The first thing of course is that, oh it is a spiritual problem and it is

something that has been inflicted by diabolic means. Or it is something that used to happen to his grandfather, so there is nothing they can do about it. For most people, that is the impression in the society and of course that is what the media is presenting. The media can change that by getting knowledge; acquire information before they shoot the movies. They could psycho – educate the public through the movies by depicting the orthodox belief as per causes of mental illness as well as the treatment modalities that are available. We are Nigerians and we are Yoruba's and diabolic activities is entrenched in our beliefs and in our society. Even, this has been carried over into our religions. It is said that, 'they have shot this person an arrow'. 'Arrow' means that the person has been remotely inflicted with mental illness. Of course the will also have prescriptions, they will have procedures that will also kill that remote affliction of mental illness. So, it is not out of place, we are firstly part of this culture. But now, the education now has its own role which enables a person to suggest orthodox means for healing, which when adopted, brings about relief for the affected person.

Question 32: can there be a meeting point between what is entrenched in our tradition and what is operational in the orthodox mental health care?

Interviewed: well, that is a new one. But I think some similarities right. Let us look at some of the similarities in terms of symptoms. The symptoms are real anywhere in the world irrespective of the culture, the symptoms are universal. The causes are different but the symptoms are universal. The methods of treatment are also different and of various methods i.e. the spiritual and the orthodox. The symptoms are similar and that is one meeting point.

In some of the modalities of treatment, whether it is spiritual or traditional, though between the traditional and the spiritual there are some similarities. They ascribe most of the causes to external forces or the devil and things like that.

Question 34: Does your profession acknowledge the spiritual means?

Interviewed: No, no. we don't. My profession is more scientific. It is what we can see that we report. In terms of the meeting point, part of the procedures for treatment also appear to be similar. Some of the medicines that the traditional healers use are actually plant extracts some of which has been linked with some of the medications that are used in the mental health. There is a particular plant '*urofer alcaloids*', in Yoruba it is called '*Asofeyeje*'. It has been known to have very strong potent sedative effect especially it has been used for people who are extremely psychotic. Once you take them, you get calmed. The first thing of course is to calm the patient. So, we agree that we can calm with an agent, with some medicine, whether it is tablet or liquid - that is a form of agreement. We agree in that area. So if this person is responding to my concoction made out of '*Asofeyeje*' or my tablet, there is an agreement. That means that this person is responding to something. It is only when the traditional person says that he has invoked some certain things. Of course what the orthodox person does is to give medication, use it and you will see the result. The '*urofer alcaloids*' agent when they give it their patients, they begin to see the effect as well in that person. Even, some of our grandmothers used it as part of the leaves used to prepare native concoction for malaria, to give sedative effect to allow the person to sleep. It has established sedative effect. That is another form of agreement there.

Again of course, the issue of involving the family in the treatment which is a very strong point especially at 'Aro' (one of the major Psychiatric Hospitals in Nigeria and located in Abeokuta), that aspect was actually included in the program over there. 'Aro' at Abeokuta is more rural. So, in order to capture or to encourage people, they created a village, 'Aro Village' where people after receiving treatment with the hospital, can now go and begin to live in the small community. So, that helps a lot. Even, families of these people can also come around and be a part of the healing team. Most of the traditional healers involve family members who will come, they discuss certain things, and family members make their own contribution, similar to the spiritual treatment. So there are some common fronts that we can actually agree on especially in terms of the symptoms that are available, procedures that are used, and the use of drugs or concoction as it is used. And of course, behavioural therapy is also carried out too by these traditional and spiritual healers.

Question 35: Would you consider the orthodox method more efficient than the traditional methods?

Interviewed: Yes, I will consider the orthodox method as more efficient.

Question 36: Can what is prevalent among Nigerians of attitude towards seeking professional mental health care be referred to as a construction of reality or an unending effect due to heavy exposure. Would you say the attitude of Nigerians about seeking professional health care is as a result of what is obtainable and in existence in our society, or it is an effect of the heavy exposure to contents depicting mental illness in the media?

Interviewed: Both, I guess it is both. Of what is available, there are not so many mental health facilities in this country. In fact it is very, very poor. I am not sure but I think we have about twelve basic psychiatric hospitals in this country. I am not sure of the total bed space but here – the total bed is about 500. I don't have the statistic about other places but here there is 500. 500 times twelve will give you about six thousand beds I guess. Some of the teaching hospitals will have a smaller unit of smaller beds of twenty in about twenty other hospitals, that is about four hundred plus six thousand. That is about six thousand four hundred beds for mentally ill patients in about a hundred forty million Nigerians.

Question 37: A report says we are about 170 million people.

Interviewed: Well I am only trying to be conservative.

Question 38: One out of how many Nigerians will probably have mental illness?

Interviewed: One out of ten thousand will get a bed. Statistics says that for depression it is higher. But generally, about 6% - 7% of Nigerians have mental problems. Some people will give higher but studies have restricted to about 6% - 7% will have some sort of mental illness or the other and that is about 12 million Nigerians, who will really have psychiatric mental health issues that require assistance. The larger percentage will have this condition but they are still surviving. They will actual say I am suffering and surviving and moving on. About 6%- 7% do require assistance.

Question 39: would you say that the attitude of Nigerians about mental illness is as result completely of their exposure to what is prevalent in the movies i.e. the media or

it is vice – versa? Is it the media that is actually influencing the attitude of Nigerians or it is the populace that is influencing the media?

Interviewed: Oh, in that case, it is the populace that is influencing the media. The media will report what they see. Our movies will report what they see because that is what will make meaning to who will want to watch it. If it is not what they think or feel, then there is no need to watch the movie. They won't want to watch it. When a producer wants to produce any movie, he wants to see what is there. So, if you want to know more about peoples believe, customs and attitude about certain things, take note of the movies that they watching. So, you will have a deeper understanding of their own believes and behaviour.

TRANSCRIPT OF THE INTERVIEW: PSY TWO

Question 1: My name is Khadijah Aroyewun – Adekomaiya from De Montfort University and I will like to ask you few questions. Can I meet you Sir?

Interviewed: My name is Dr. ... I am a Consultant Psychiatrist with Federal Neuro – psychiatric Hospital, Yaba here.

Question 2: To start with, what do you do as a professional?

Interviewed: Usually, I provide mental health services for patients who have problem with depression, schizophrenia, drug and substance abuse, old age related psychiatric problems.

Question 3: Do they come on their own?

Interviewed: Some come on their own, but many are brought in by the family members.

Question 4: Like I said, my topic is the role of the media in influencing the attitude of Nigerians towards seeking professional psychological treatment. Is information about orthodox/ professional mental health care readily available to Nigerians?

Interviewed: It is not readily available.

Question 5: Why do you say so?

Interviewed: Because, mainly there are few professionals available, so that will limit the information. The access to the media is not so much available basically if it is the hospital that wants to say something to the media, you may even have to pay to do it. And the hospitals probably have funds which are for so many other things, and these funds are not so much. Basically, it may not be so easy for them (hospital) to do. What we do here at the hospital is to go to the public; go to schools to provide information on drug abuse, go the motor park, go to the market, to talk about what to do when you see these symptoms, health talk generally which is directly to the public. Talking about media like the television and the newspapers, they are not regular media that we adopt.

Question 6: Do you choose these other form of disseminating information because they are cheaper?

Interviewed: Yes, they are cheaper. Even at that, as much as we are trying, it is not enough. Just like I said, it is the same nurse and doctors that work here that will have to go. So, they will definitely have a lot of work to do which will definitely not be enough as it is not going to be as regular as it ought to be.

Question 7: Please, from your experience, what is the first point of contact for most that visit the clinic?

Interviewed: The first one is the traditional or the religious to a large percentage of them, when you look at the part way to care. For quite a number of them, the first time they notice this, the first place they go to. Many still don't believe it is a medical condition. They think it is a spiritual problem or whatever. Mental illness is still shrouded in a lot of mystery in this part of the world. People still feel this way except for people who are educated, (though not all the time) or people who have someone who is working at the hospital. Your level of education doesn't necessarily affect the perception about mental illness. I can't give a percentage but I am aware that some people have done research on the pathway to care and the result for those little researches done was that people go to the traditional or religious people.

Question 8: When would you say the orthodox/ professional means of seeking health started?

Interviewed : That is an historical thing, for example this hospital is a 107 years and we have an older one that is 109 years old, that one is in Calabar, I am not sure now but this hospital was established in 1907. Then it was a custodian thing. It was like an asylum because even the first medication that was approved for mental illness was in 1954 all around in the world. So, it is a very relatively young profession all over the world even in Nigeria. Majority of them were custodian because they try to keep the mentally ill away so they won't constitute societal menace; so they thought. But later when drugs began to come, which was around the fifties, it became a full-fledged hospital.

Question 9: Would you imagine the professional means of treating the mentally ill replacing the traditional form?

Interviewed: It is not likely (to replace the traditional way of treating) completely. Imagine like fifty years, some people still don't have access to these hospitals that we are talking about. This is Lagos, which is probably one of the most developed parts of the country. In some villages, they don't even have an idea of orthodox mental health. Most of them still go to their local Mallams or traditional healers. The margin will be like fifty year or whatever. But in recent times, it (traditional) is not likely to replace orthodox mental health.

Question 10: If the media is playing a particular role, do you think the actualization of the above question could be fast tracked?

Interviewed: Yes, it can be fast tracked definitely. Because information is getting to more people and if the information is persistent, and they are able to provide prove that this thing works, it will definitely fast track it, definitely.

Question 11: Is the media playing any role presently in providing information about mental illness?

Interviewed: They do but then, most of the channel they provide is inviting the professional which is not a very common practice. The most time when they talk about mental health is when reporting, especially that someone who is mentally ill did something, maybe committed some crime or whatever, that is the one they pick. But the only time they can provide concise information is when they invite professionals but it is not very common. Most of such programs are usually sponsored. Unless one or two NGO's come in, which someone must be sponsoring regularly, which is also not regularly available? Occasionally they invite us, like in Yaba, we have like two programs. It is not like we have NTA (a national television station) giving us one hour every week, when it is not like we have sponsors. We have to go out and look for sponsors. But because the fund is not available, the program will die naturally.

Question 12: What role is the media (the movies and newspaper) playing?

Interviewed: For some of us that don't watch movies, I am not a fan of Nollywood movies.

Question 13: If not the Nollywood movies, how about the newspaper?

Interviewed: Even if I am not a fan, I have heard people say they are mentally sick because somebody did something to him. You have a step mother who did something. That is the way the movies portray it. At least if I am not a fan, I know because sometimes they do a preview in the newspaper. I get more my information from the newspapers. For the movies, because that is what they believe which is what the African mentality is to a very large extent and they don't have information from the professionals. Only very few who want to add something about mental illness ask the professionals. They just go ahead and most of the time, they portray someone who has a breakdown as someone who has done something bad, so it is a punishment for that thing or somebody somewhere want to harm him or whatever. For newspapers, what is common is reporting something and most of the time it is negative. Recently, somebody kidnapped a six years old child somewhere in Ikorodu, they brought the person to check for the person's mental stability and this has become a media issue, it is on the front page. More often than not, if this person is found to be mentally ill, it still doesn't help the mentally ill - whereas you will found out that they are not really violent. There is probably more violence committed against them than they committing violence. The few ones the media contribute are when they have guest columnist, they have health experts and sometimes they invite psychiatrics too. But if all television has like thirty minutes in a week of health issues, usually they invite doctors and even mental professionals.

Question 14: You did make a reference to the newspaper's representation of the mentally ill as mainly a news report which often times than not is always attached to a criminal act, is that correct?

Interviewed: Yes, more often than not. It is usually sensational, abnormal behaviour, because they report on what they see.

Question 15: What do you have to say about the report on the Paralympics athlete who killed his girlfriend and it is always in the newspapers?

Interviewed: Pistorious?

Interviewer: Yes, Pistorious.

Interviewed : What I feel really is that if anybody commits a crime, mental illness is usually is a form of defence in court and more often than not, you get a lesser sentence, by claiming they were not aware at the particular time of their action in order to lighten their judgment.

Question 16: Is that possible with mental illness?

Interviewed: It is actually possible if the sickness is on at that particular time. Someone who is not mentally ill can commit these crimes. So more often than not the court might release a guilty person on the pretence of mental illness, which is a problem for the court. The professional experts is usually invited to ascertain the mental stability of the suspect because you need to be mentally fit to stand trial and to be able to answer for that crime.

Question 17: From all these constant placement of the mentally ill with violence and aggression, can the media be blamed for that attribution?

Interviewed: Yes, they can be blamed because they don't try to verify information from experts before reporting it. The media should talk to people who are experts and it is your job to now report it. When you talk about violence, it is a norm: if every time you get information that mental people are violent, people will want to stay away from them instead of taking them to the hospital, whereas it doesn't work that way. Sometimes, the media exaggerate the reports through the headlines when eventually the reports states otherwise. The media have some level of blame which is peculiar to wanting to make more money and sometimes ignorance.

Question 18: Do the media present undistorted view about Nigerians in relation to mental illness? Is what the media i.e. movies and newspapers, present about the view of Nigerians about mental illness a true representation of what they believe?

Interviewed: Though there hasn't been a research to that effect, but many Nigerians actually think that what is usually reflected in the media is the cause of mental illness. That somebody is punishing somebody or it is a punishment for something bad that you have done in the past, i.e. diabolical reasons. Because they have grown with it, some will come to the hospital and say that they just want you to tackle the medical aspect and that they know how to deal with the diabolic cause of the mental illness, for the movies. For the newspapers, they usually just report except in cases where they invite the professional. They add something and remove something because they might not be the eye witness there. Sometimes they do opinion polls, which provide a platform to provide professional and expert view on mental health. The clerics in the churches and in the mosques are not helping the matter because they also work in the direction of attributing mental illnesses to diabolic reasons. These clerics hold a lot of power among our people.

Question 19: In the newspapers, for example in the Punch, my study so far of the content on mental illness so far from June 2013 – June 2014, there seem to be a lot of write ups about mental health care providing information. Would you consider them enough?

Interviewed: There are some columns in the newspaper for providing information about mental health care but they are not enough. Adeoye (one of the major writers in the Punch newspaper on mental illness) is doing a wonderful job. It is not enough definitely. One, how many people buy the newspapers and for those that buy it, how many people can understand what is there. So, basically it is not enough.

Question 20: Considering what you have said, what role can the media play in influencing the perception of Nigerians about mental illness?

Interviewed: The role mainly is to create more space for especially the specialist, because anybody cannot just talk about mental illness. And if there is any issue about mental illness that is in the public domain, the media should actually get back to the professionals. Which some of them try to do but some of them just write the stories because the story must sell too and you may not be able to get access to a professional at that time, but you may get a professionals view even a day or two after publishing a report. I acknowledge the essence of timeliness in news reporting but professionals should still be sought for an expert view on these issues.

Question 21: The individuals that you see, i.e. your patient, from your evaluation can you make a reference to the media impacting on their perception of mental illness?

Interviewed: Some of them; what they hear from the radio or television surely impact.

Question 22: How much information will you say the media is providing about some of these mental illnesses such as schizophrenia, ADHD, depression and autism? Is the media doing well enough so far?

Interviewed: Definitely not. Like I said the venue for communication is still very limited. The basic requirement is for information that you should seek for help from the right places, when you detect any mental illness symptoms in someone around you.

Question 23: The results of some research have actually revealed that most Nigerian movies depict and eulogize fetish reasons and causes of mental illnesses, does this in anyway impact on the behaviour of the mentally ill?

Interviewed : I think it should because if they watched the movies, someone who is mentally ill themselves, more often than not, people see these movies as what is happening in the public domain, so it will just probably entrench that believe in them that these person or somebody else is responsible. It is just like somebody with psychotic disorder who hears voices, the voice of the person you are hearing which is just a symptom you are likely to believe that the person is talking to you especially when you don't have a pleasant relationship with some certain people such as your step mother. It actually influence their behaviour when their believe system is the same and especially when they are using the drugs. So, it does.

Question 24: In what other ways does it impact on their perception of mental illness?

Interviewed: Since it is actually in their belief, it will affect their coming to the hospital; some don't take their medication because they feel somebody else is responsible for the mental illness. What the hospital preaches is that this is a physical illness, and causes may be physical injury to the head, abuse of substance, some other illnesses that led to mental illness. We too are not sure of the cause really but it

can be treated. If a mentally ill person or anybody believes in diabolical causes of mental illness

Question 25: Do you as a professional believe in the fetish, spiritual and diabolic reasons for mental illness?

Interviewed: No I don't

Question 26: If you don't, do you believe that there could be a meeting point between the professionals and the traditional healers

Interviewed: Yes, there should be and there could be, because before we began to use western medicine, they have been using something. Some of those things they used are actually what people developed into tablet basically. There should be and sometimes they even have their own method of taking care of the ill which has similarities with the way modern medicine is treating the mentally ill. When someone uses substance, the traditional method has its own medicine that it uses. It is not everything with the traditional method that is bad. We should be looking at what we can gain from the traditional medicine just as China did, which we have not done in order to help the patient. The traditional and the orthodox should have a meeting point. Whether you like it or not, they are still going there, so we should look at what they are doing for them traditionally that is bringing good results.

Question 27: Are you pleased with the depiction of the mentally health in the media (movies and the newspaper)

Interviewed: Definitely not (repeated thrice for emphasis), it is a wrong way of depicting mental illness.

Question 28: Can the present depiction of mental illness in the media (movies and newspaper) be said to be what is obtainable or entrenched in Nigerian culture?

Interviewed: Yes it is, but I just feel the media should be more enlightened and show the proper way things should be. That is the belief of the generality of people which is in line with their own believe too. A media should provide more information by searching for information, that way you are giving them a better alternative. Occasionally, the movies have contacted us at the hospital before making movies about mental illness. We have even invited some actors in order to educate them on mental health care.

Question 29: Are you doing more of that?

Interviewed: No, like I said because all these things requires funds, many of the government and the NGO's don't partake in mental health care possibly because of stigma or there is not much money there. People are involved in HIV/AIDS and other health care issues that the effect of their involvement can be counted, e.g. these were the number of children that were born, vaccinated.

Question 30: On a scale of 1- 10, what is the cure rate among the mentally ill?

Interviewed: You can't use the word cure when it comes to mental illness, because cure means you do something and the ailment disappears and just like some chronic illness like diabetics, high blood pressure, etc. More often than not, these diseases are

managed rather than cured, but you can live your life to the fullest. Only the mild ones can be completely cured or eradicated. The rate of default with mental illness is higher because patients who are on continuous medications could get discouraged after their visit to the church. We lose quite a number of them to follow up because they miss their appointment for sometimes in a year because they think they are feeling better already. It is known all over the world that the mentally ill can live their lives to the fullest through regular usage of their drugs. Though they might have to use their drugs for a long time, but with drugs and psychological treatment, they can live their lives to the fullest.

Question 31: Are you referring to years of painful treatment?

Interviewed: What do you mean by painful?

Question 32: For example, like cancer, you go through chemo – therapy and this can be a little painful, which is of course a means to an end.

Interviewed: It is usually tablet and maybe injections could be painful. Mental illness is more of emotional pain or distress, a person feeling that he should just kill himself, wanting the world to end, suicide.

Question 33: How about societal distress?

Interviewed: This is possible when someone charged with taking care of the mentally ill is not able to go to work. Or the mentally ill himself is a teacher and he can't do his work and he has children. The society will be affected if one way or the other he is unable to do what he is supposed to be doing at a particular time.

Question 34: Mental illness in comparison to cancer and HIV, which is deadliest?

Interviewed: Mental illness is not directly related to death and not life threatening and that is why people don't take it serious. The other diseases are deadlier in comparison to mental illness.

Question 35: When you referred to NGO's, were you saying fewer involvements of NGO's in mental health care or non-involvement?

Interviewed: We have some NGO's that are involved such as those that sprang up because a member of the family became mentally ill.

Question 36: Would you consider the orthodox mental health care more efficient to the traditional mental health care?

Interviewed: I may not be able to say so much about the traditional mental health care. Some people claim that doctors suggest visits to traditional health providers, but a properly trained medical practitioner will never say that. If it is beyond you, you go to a higher authority. I can't refer you to traditional health care when I do not know what they are doing.

Question 36: Would you say that what we have in the media is just a reflection of what we have in the society or vice – versa?

Interviewed: The media is actually depicting what is in the society. What I expect of the media is for them to do research in order to present the proper perspective of mental illness. What is depicted is what the majority of the people believe. The media sometimes refer to the relayed incidence as a true life story. I expect the media to do more than that because they are there to inform and educate the society.

Question 38: Can mental illness ever emerge due to fetish reasons?

Interviewed: I find it difficult to believe because these mental illnesses we are referring to happens all over the world and in places where fetish activities do not take place. And symptoms of mental illnesses are similar everywhere in the world, cause mental illness as to do with physical function of the brain. I find it difficult to believe that somebody somewhere can be in control of your life.

TRANSCRIPT OF THE INTERVIEW: PSY THREE

Question 1: Thank you so much for participating in this interview with me. My name is Khadijah Aroyewun – Adekomaiya from De Montfort University, Leicester. May I meet you Sir?

Interviewed: My name is ..., Head of ... services, Federal Neuro – Psychiatric Hospital Yaba.

Question 2: Basically, my research topic has to do with the role of the media in influencing attitude of Nigerians towards seeking professional psychological treatment. To start with, what do you do as a professional?

Interviewed: I am a clinical psychologist. My primary assignment is to provide patients who come to the hospital and that could actually benefit from psychological intervention. If you are going to look at the psychological intervention, it comes in different forms. Before intervention, there must be an assessment and evaluation. We do evaluate first, then look at the treatment alternatives, look for the best intervention that will actually help the patient. That is one of the things I do primarily as a clinical psychologist in the hospital. My role also involves research and also training for students at various levels sent to the hospital.

Question 3: Considering your expertise and experience, would you say Nigerians are informed about professional mental health care? When I use professional, I mean the orthodox means of providing mental health care and when I use traditional, I mean the unorthodox, spiritual mental health care.

Interviewed: On the surface, it is assumed that they are informed but if you look at the approaches which people follow when it comes to mental issues, it comes in various forms, despite the ‘Community Outreach’ and the enlightenment programs like for example, we still see people seeking other means of treatment for the mentally ill individuals; from going to seek the help of a traditional healer, Muslim clerics or pastors in churches, despite the level of education of some family members. I have seen a professor, who despite his exposure and education still believe that the problem of his son is spiritual, so rather than go orthodox, he decided to go spiritual

and at the end of the day, the boy still had to be brought to the hospital after they have gone shopping round for treatment at various spiritual centers. I always refer to my situation; we do a lot of community outreach to educate and enlighten people about mental illness. But I think the government still has a role to play because when we talk about mental illness, we talk about stigmatization and a lot of people don't want to associate with such conditions. It is one condition people tend to turn their face off from or shy away from.

Question 4: You mentioned an outreach you employed as a means of providing information about mental health care to the Nigerian populace; can you mention the media that you are employed?

Interviewed: The hospital has a committee i.e. the 'Hospital Community Outreach' - which was set up by the management of the hospital, which provides talk on mental health care by going out to local governments, parks, centres where they can be easily have access to people, offices, popular places where you get people to gather. They attract people with drama. For the media reach, what we usually get here is - people who come in; probably the journalists or a press person is writing about a particular topic, that is when you see members of the press coming to the hospital to speak to professionals and get our expert opinions.

Question 5: Have you ever had the opportunity of working with movie content producers in order to influence their outlook on what mental health care is all about?

Interviewed: I have actually not done that but I have gone on air on several occasions via television, via radio - to talk about mental health conditions, to educate and inform about signs and symptoms people will observe when they see a family member going down with some of these psychopathologies.

Question 6: From your experience, what is the first contact for mental health care among visiting patients?

Interviewed: It depends - we are going to look at it from different dimension; some family members would actually take the individual first to a normal hospital and when they get there and the physician/ doctor there does his assessment and feel that he will not be able to manage it, such individual might be referred to this hospital. Like I said, some will also go to spiritualist for help and when they have tried those spiritualists, they still come back to the hospital and probably, some come here directly. They come to the emergency unit.

Question 7: Do you have a lot of people coming to the hospital directly?

Interviewed: A lot of people do come directly.

Question 8: Have you sampled their opinion as to why they chose to come to the hospital directly as against visiting those other conventional first contact?

Interviewed: I will talk from experience, in some cases at the emergency unit, we see some twenty to twenty five cases on a daily basis and some of those referrals - recommendation come from friends, who had had treatment at a point in time or the other or some from other hospitals which treat other conditions that are not psychiatry.

Question 9: When would you say professional mental health care began to take shape in our country Nigeria?

Interviewed: It's been long. I would always refer to my own centre because the hospital came into existence in 1907 and which is one of the oldest psychiatric institutions and it initially was an asylum and it has gone through faces over the years. The asylum years to the tears of keeping people who have mental illnesses in rooms to prevent them from the roads. The treatment phase, which became prominent in the sixties and seventies with the use of pure psychiatric medication. In the seventies; the use of therapy and what we have today now, which is full-fledged intervention with the use of chemotherapy and psychotherapy, became prominent. It came through that phase in Nigeria and I will use this as yardstick at Federal Psychiatric hospital, Yaba which is over a hundred years. We did our centenary in 2007.

Question 10: Do you see the orthodox treatment style completely replacing the traditional / unorthodox method of mental health care?

Interviewed: Yes, I will say authoritatively from my scientific experience that the orthodox is the best form. It will actually replace the unorthodox treatment of visiting an herbalist. In the orthodox form of treatment, we have a treatment plan which starts from when the patient comes in; the method of restraining even when the patient is violent is quite different from what you will see in all the unorthodox centers where the health providers result to violence and wiping of the patient and all that.

Question 11: Is the media playing any role in providing information about mental health care?

Interviewed: If we want to talk about the media, because I read newspapers a lot, you will see some newspapers that have columns where we talk about health issues and occasionally they focus on mental health and they discuss various topics - where they educate and inform people or provide knowledge about mental illness for people to work with - that is for the print. In some other cases, at times it is discussed on television. There was a program that was on for some time which featured a presenter that usually talks about mental health conditions but I don't see it any more. I am aware of a program on television called 'psychology and you' where the presenter looks at issues around mental health care. Besides that, not much. I will score the provision of information by the media in Nigeria probably a 40%.

Question 12: Since you have admitted that the media provides information about mental illness, would you say that what they portray is the correct perception about mental health care? Let us look at this in the context of the Nigerian movies.

Interviewed: I have seen a couple of movies where people have to feign mental illness the way it is feigned, it is just for the people see that this person has mental illness but the treatment modalities and interventions is not feasible because they might not have contacted an expert who would have been able to use the normal terminologies or actually draw a conclusion about how to manage such conditions. It is just a normal general practitioners view or approach towards the treatment of mental illness. I have seen a couple of movies whereby they present a fair presentation of mental illness but not as expected.

Question 13: Most Nigerian movies, are you pleased with how do they portray mental illness? What approach are you pleased with?

Interviewed: It is just a movie because they are definitely actors. It is just to portray a particular scene in a film. Probably, where you see the person been tied down on the bed, he or she is displaying some abnormal behaviour which any other person will be able to pick, there and then you don't need an expert to tell you this person has mental illness, because he or she exhibits overt behaviour which is observable, you don't need an expert to tell you. Where an expert is needed is in the intervention method where you sometimes see the patient been sedated with an injection and immediately he calms down in the movies. At least, they have done an intervention method to arrest the restlessness or the violent approach.

Question 14: Some research results have revealed that Nigerian movies depict and eulogize diabolic reasons as causes of mental illness. How does this impact on the behaviour of Nigerians towards seeking mental health care?

Interviewed: If you look at Nigerian movies, especially the ones that are done in certain parts of the country, which indicates that someone actually used diabolically means of making an individual go mentally ill through incantation and that is what people will pick. The movie is expected to educate. I, as a scientist don't believe – which is some of the things we use as treatment to educate or enlighten family members pointing out to them that their ward has become better via orthodox intervention after few weeks of commencing treatment, without the involvement of the herbalist or traditional mental health care provider, or pastor or Islamic cleric to come and pray their ward. We tell them that we have been able to do this with the use of medications and counselling or psychotherapy where required to deal with that individuals problem. It is like telling them that it is science and orthodox method of treatment that would make an individual get well

Question 15: Do you then agree that the media has an impact on the attitude of Nigerians towards seeking mental health care.

Interviewed: Yes, I would because it is what they see that they would believe and is what is being portrayed. We should also take into consideration our cultural believe. We are Nigerians with different ethnic backgrounds and these ethnic backgrounds have their own different believes, but besides all theses, they could be some other factors responsible for someone breaking down apart from there believe that an individual was afflicted due to diabolical means.

Question 16: From all the things you have said, will you say the media is simply just reflecting what is obtainable in the society or is it that the society has adopted what they have seen in the Nigerian movies? Who is influencing who?

Interviewed: It is two ways, the media guys are an offshoot of the society, and they are part of the society from their experiences. And it is from their experiences, goals and objectives that they come up with news that they report to the society. As a journalist, you have to do research, interact and get information, put it together and then actually report it. It doesn't come from the blues or it doesn't come from the sky. You have to interact with the people, draw your conclusions, draw your inferences and do your report – then inform. It (Who is influencing who can be said to be) is vice –

versa. The big questions are; is it representative enough? Is it actually happening or is it true or false?

Question 17: What role should the media be playing when it comes to mental health care?

Interviewed: It still boils down to what we started with; discussion with experts on the fields. When we talk about mental health, we have many professionals there; the psychiatrics, psychiatric nurses, social workers, occupational therapists, psychologists and other professionals in that cadre who have different fields and interact with the patient from different professional angles. The media needs to speak with these people to gather from their experiences by interacting with the professionals, taking note of the treatment modalities in order to equip them with information (about signs and symptoms of mental illnesses that can be looked out for in families and friends), which they can provide to their audiences.

Question 18: Can there be a meeting point between the orthodox and traditional means of mental health care?

Interviewed: That is a good question. I am sure that there must have been forums in the past where they had interaction, but I don't think there is any formal or any official meeting which I have heard of. But in some cases, I have seen a lot of unorthodox treatment providers work hand in hand with orthodox treatment providers, because some of them even use medications. They get medications from professionals in orthodox treatment, which they grind and give to their patients with water or as 'concussion' and the person calms down and the traditional gets a thumb up for that treatment. This could be another way forward to see if there could be a form of sensitizing the local providers to see what they can provide in their localities, because orthodox came, they have been managing patients with mental disorders in the past with their own various herbs, that worked. It might not have worked in full optimal approach as orthodox would have but they will be able to provide palliative measures in such conditions.

Question 19: What suggestions do you have for content producers, particularly, Nollywood producers?

Interviewed: If you have to do a film that entails depicting mental illness, they should speak to experts before embarking on such projects because we are talking about providing information on what to do and how to react in cases of mental illness because it is what you sell the public that the public will take home.

TRANSCRIPT OF INTERVIEW: PRO ONE

Interviewer: I am glad and grateful to you for agreeing to conduct this interview with you. There is need for us to understand that when I use the traditional mental health care, I mean the spiritual (i.e. visit to pastors, Islamic clerics the conventional traditional in our culture which is the visits to herbalists. When I refer to the orthodox or professional mental health care, I am referring to visits to the hospitals to meet with professionals such as the neuro psychiatrics or the psychotherapists. If you don't mind this asking, how many movies have you produced that have depicted mental illnesses?

Interviewed: 'Obiripo' was about the first one. I have produced so many movies but when you talk about solution to mental problems, its only 'obiripo' that has that touch.

Question 2: How do you come about the stories you write for your production?

Interviewed: My stories, I always pick issues, like let's talk about this 'obiripo' thing, you see, my father used to have a friend when he was alive, the guy was a lawyer, I don't know if he is still alive, but the man, his friend was a lawyer. There was a day they were talking about their past, and a little boy that I was, I just stood there, and the man was saying something like, when he wanted to sit for entrance examination into secondary school, his father did not give him money but gave his younger sister the same amount of money to buy beads that she will put on her waist. So, I just picked that and the man was about crying and he said somebody else, he didn't even say the principal, he said somebody else gave him the money to purchase entrance form. So, when I now became an artist, the story just came, I remember that story that his father did not give him money, somebody else did, and the father gave the same amount of money to his sister to purchase bead, so the story started developing and (clapped his palms once) I made a film out of it.

Question 3: How about the mental aspect?

Interviewed: That one just came when I was screen playing the film, that aspect of the mental theme just came, how would the boy and his mother encounter more problems. So, that one came along as I was writing the script.

Question 4: Why did you decide to feature him (Enitan in 'obiripo') crying, you know there was this part when something was upsetting him (Enitan) in the middle of the night?

Interviewed: There was this problem he encountered when he met the woman he loved, really loved, not even the lady that became a psychiatrist later. There was this area of the story where the wife will say let us go and meet your people. One, there was that fear of Enitan taking her home if only to see the father because he was afraid of what might happen to his family. He was worried that if something like that could happen to his mother, he was worried that same thing could happen to his immediate family. Now, ok, if you cannot take me to your father, how do we meet your mother. There is that fear again that if I take her to my mother and she gets to know that my mother is sane (insane), she might get to leave me, not knowing that the woman God has chosen for him is really somebody that will stay, whatever the problem is.

Question 5: That aspect of that movie of him not wanting his wife to know the mental state of the mother, what informed it? Have you seen someone who shied away from opening up to the fact that his mother has a mental illness? I mean, in our movie, Enitan is supposed to be an educated man, well for one reason or the other, it didn't occur to him that there could be a professional solution to his mother's illness or mental state of health, why did you chose to approach it that way? And you know for a long time, he didn't even show up, because he was filled with regret and with sadness because of his mother's state of health, so why did you choose to adopt it that way?

Interviewed: When you are making a movie, we have to put what we call suspense to hang people, your audience, you have to hang them in a way that they will sit tight

and want to see how you are going to come out with a solution. If you look at the situation very well, I did not even say after a few years. I just put it that they met and before we know what was happening, they were already living together and the next time we see them was gbam! Enitan was crying. I also started with the problem as something he will not tell his wife. Now why will he not tell the wife; we have so many different women, while some women will weather the storm with you, some won't. We now try to test the love that exist between the two and that is why the woman will say a line like, "tell me that thing that weigh so much on your chest that you think the whole world will crash if you let it out you tell me and see if I will stay" at a particular time the woman said, "does this concern your mother?" and the guy had to shout, "no". Do you understand! The problem is so heavy in him and there is that person that is ready to share that problem but he doesn't know if he had to do like that or let it go because he doesn't want to lose the mother of his child. That is why I deliberately put a child between them. If this woman hears that I have a mad mother, would she go with the child. So, I put that problem there, the child. But at the end of the day, when he found that the problem is getting too much, this wife will not let me be and she is even saying let us take the child with us. The kind of wife he has, he said ok, let's go. And you look at the situation; they were just going all over the place. Is it that he doesn't know the house again, why are we perambulating, why are we going all over the place, why are we checking dust bin areas, why is it that upon the hills and dirty places? When they now met the mother at the end of the day, they met the mother been beaten. I intentionally created that scene that this son will witness what has really been happening to his mother. When they now saw the mother, the first line that came from the guy to the wife is, "this is my gold. That is why I named her 'Wura'. Wura in English means gold". And the guy said, "Gold is supposed to be kept in a place that is good, a neat place but look at where my gold is, upon the heath, I mean in a dustbin area," that kind of thing. The wife now replied, "I will not because of this leave you. If this is your mother, then she is my mother too". The husband asked, "Where are we going now? What do we do now?" the wife said, "We are going to the hospital where she would be taken cared of". What he has never thought about before.

Question 6: That's an amazing touch. You said 'Obiripo' seems to be your only movie that has portrayed a hospital combining the use of orthodox and traditional (herbalist) mental health care, what informed that idea of adopting a middle ground between the traditional and professional healing method?

Interviewed: I do not want to rubbish any area of solution that may come from probably orthodox and the unorthodox. And I believe that there could be a way the two can meet and proffer solutions. That is why I started with the lady being a student studying medicine and she has a father who is unorthodox/ traditional, a '*baba alawo*' (herbalist) kind of thing, medicine man who uses herbs and other to cure. So has she was going for her training on orthodox as a student of medicine, she was also learning from the father. At the end of the day, you know there was a time she brought herbs and all the rest of them and Enitan was thinking aah; you want to harm me because I am having an affair and *blah blah blah*. But at the end of the day, what she was been blamed for was now used for his own mother. What he was blaming the girl for became what the lady now used to cure the mother.

Question 7: Now back to you been a veteran and a movie producer and a Nigerian; someone who has hailed from our culture and norms. Some way or the other you produce movies, so striking a balance between the two things you represent; a producer and a Nigerian, are content in our movies reflectors of what is evident in our

society? Would you say that what we have in our movies are mirror images of what we have in our culture Vis – a – Vis mental illness? A research revealed that most Nigerian movies depict that the causes of most mental illness are fetish and unorthodox; like you have actually wronged somebody and that is the reason why the person has become mad and of course it was reflected in ‘*Obiripo*’ too. She (Enitan’s mother) didn’t do anything at first but the step mum became mad too cos that had to be the consequence of her action. So, often times than not, most Nigerian movies, amazingly when ii started watching ‘*Obiripo*’ and I saw that aspect of Enitan crying, I almost related it to the fact that he is also suffering from depression basically because his mother is ill but later when I realized that, fine, there was no link between the two and there is no way I can make such an inference because there was no deliberate reflection of that in the movie. So, would you say that content in the Nigerian movies are reflectors of what we have obtainable in our society about mental illness?

Interviewed: Yes, yes, yes, in fact in totality because we pick what we write about from our immediate environment, from what we hear, what we see, what stories that people tell. So,yes.

Question 8: Now, would you say the combination of the traditional and orthodox method is a fragment of your own imagination?

Interviewed: Let me say something here. If she has been made mad, if she has been put in that condition in a fetish way, there is that believe that things like that, you can use orthodox medicine probably to bring him to sanity. But then, let us not forget that whoever has made her that must have used herbs in way so it is herbs too that should be used to attack such things, I want to put it in a way that you ... leaves and herbs to make him mad, leaves too... the lady was saying that she used ‘*Ori Eku*’ (rat’s head) and all the rest of them. I did something, gave the actress an object to be placed on the woman’s head which of course means that everything that is happening to the woman is around the head, around the brain.

Interviewer: That depiction is diabolic, don’t you think?

Interviewed: That’s it. I did it in a way that she places the thing on the woman’s head which means that it is the brain that is troubled. After placing it, she had to go into trance too which means she too has also gone diabolical, cause she places the thing and closes her eyes and had to go, hmm ok! ok!. It tells in a way that placing the thing and having gone into trance like that, she must have known the level of the woman’s mental alertness. If it is 100 and you know she has been taking care of her, she want to know at what percentage that thing is. She would be able to tell that she cannot go now; we still have to talk more and all that. So, in a way, while she was attacking the thing orthodox way, she had to go to traditional way because she has been made mad traditionally.

Question 9: If I may ask, how much do you know about professional mental health care?

Interviewed: What I know is that, because I had to go to (Federal Neuro–Psychiatric Hospital) Yaba, I saw so many people. I saw a lot of mad people, I don’t want to use mad but let me just because I don’t know any other way. I know insanity and madness and all. So, I go to a psychiatrics office and what he was actually doing was. I didn’t see him give the guy he was talking to any drug. He was just talking and talking and

talking and the guy was kind of responding, not really perfectly but you will know that what they were just doing is giving them drugs, some kind of relaxant that will not make them probably over do things. That was all I could pick when I visited the place.

Question 10: Are you aware of the various divisions in the professional mental health care, I mean we have the psychiatrics, the psycho therapists, and the psychiatric nurses. There is an aspect of the professional mental health care that has to do with talk therapy, because not all of these mental problems

Interviewed: it doesn't have to do with Neuro ... Neuro Psychiatrists are people who have to do with the mental thing

Question 11: Neuro psychiatrics give medication; give injection but the psycho therapist also work at Yaba. After giving medications, they try to engage these patients in conversations because they believe talk can also

Interviewed: That was the one I was telling you about

Question 12: Did you ask question?

Interviewed: Of course no I ...You know the psychiatrist really said they really need to be talked to, they need to find out there mental alertness. Hmm, that was what he told me. We tried to know whether they are reasoning the way we others are reasoning and all that, so that is why they need to be talked to.

Question 13: Have you gone out of your way to figure out all the types of mental illnesses that we have, such as is prevalent among the supposed mad people.

Interviewed: I know that some in a culture, probably in a fetish way - you can make them loose their mental balance, state of reasoning, and of course if you go into drugs, if you go into like smoking hem, cocaine and all the rest of them, of course you can lose your mind.

Question 14: Do you know that other than using drugs, or cocaine and these entire drug element, and other than fetish means, are you aware of the fact that a person can become mentally ill just the way you can have diabetics, or grow a fever? Are you aware of the fact that mental illness has to do with some composition/ element in our brains, just like blood flow in our veins and other part of our body, these chemical composition of our brain, if it's is excess or is in its shortage, it could lead to mental illness?

Interviewed: No, I really don't know about that, I am hearing this for the first time but what I know is that if you are depressed, you can have mental problem. When I went to England, I saw a woman, she was, you know when women make up their face, you can always tell when this one is exaggerated, when you put on an earring in a normal situation, I said to my company that there is something wrong... we should do some findings, this person is not normal. He says, ha no that is London girl for you, she is having.., I said no, this one, there is a problem. She went like that and we were just strolling and we saw another one. So when we now got home, I sat his wife and I said we saw women, you know, she said, ha! Uncle! I think I am on your side. There are some who don't have men to marry, there are some men have jilted, so it is like the thing is getting to them. They will help men to get green card, they will help men to get their stay in America and all that and at the end of the day they get all they need from

them and run away. So when this happens, depression can set in and maybe they feel cheated and all that, you know, our women, there is a level of this thing they can take, that can make somebody mad now. So that is another way, that is another aspect that I know can really make somebody go mad, because you will just find out that she will just be shouting on innocent people without knowing the cause of their, because there was a year, very long time, I made a film, I called it eh eh "*Eyin Ogun Odun*" which means that "boomerang" which means you do something, it comes back to you. It is a simple story of a boy in the house and another mother in the house in a face to face said, *Bobo*, take care of my baby, I want to get to the market. The little boy, small boy of about seven and the baby is about a year just hold on to my baby, a baby girl, I'm coming. The small boy was looking at the girl and remembers a time the father and mother were mating and the next thing is he removes the little girls pant and had that unholy thing with her, when the mother came, she saw the baby, she was mad. Infect, we saw that one at the end of the day because we really didn't know why this young man was mad, when they now had to do their findings, they now had to see that that was what they did and the other woman cursed the boy, the next time you are seeing my child, you will bw mad and this young man just met the girl, fell in love with the girl and when they were about making love, this guy started at anything that has hole, that is what he goes for, if this is a loud speaker, he will remove his trousers. At the end of the day when they were about looking for solutions, it was now revealed that this thing that is happening to him, he has been cursed from when he was age seven, next time he is going to set his eyes on that girl, he would be mad.

Question 15: That is very, very interesting. Are you also aware of the fact, let's make a comparison. So far so good, people you know that hav been mentally ill have had to emply the traditional means of healing, how effective has it been compared to people who have actually sought the professional mental means. Have you actually had people who have adopted the two.

Interviewed: I have seen one, this one I saw , you see, when you are talking to this individual, you will think she is perfect, nothing is really wrong with her but at a particular time, when she doesn't realize that there is any body around, you will just realize that' she will be talking alone, but when she gets to know that someone is looking, she stops. You will think she is normal again and she is been taken... when the parents felt she could go home was when I saw her, when you are talking to her, she would be like Uncle ..., everybody knows her story but you will think she is okay but when you she is not aware that people are watching, she will be on her own and you will feel, when you look around, there is no body she is actually talking to.

Question 16: Are you aware of the fact that people who are schizophrenic are delusional, they have like a sixth sense working and they can actually see some things that we cannot see. They are actually living in their world and they are also living in our world.

Interviewed: I am aware of that because they talk to things that we cannot see

Question 17: This explains how magical the mind and how creative the mind is which functions with the brain. Have you seen this movie the beautiful mind?

Interviewed: But there is one thing I know, it has happened to me, I was a young guy and I was in the house watching television, then NEPA took light, I was kind of too lazy to go out, put on the candle or anything ad the first thing that came to my mind

is, who is God? Okay, God created Adam, then Eve came along the line and they gave birth to Kanine, I started having pictures, then the next thing was, okay fathers and mothers and blah blah blah, then it got to me, who now created God. There was that fear that came, I didn't know where the fear came from but it came and I had to run out, I ran out of the house. That one left like that, the issue just went like that. there was no light again and I was seeing things. What I saw if I tell you, I saw myself in a white robe with a dark robe, then set of people in white robe, then there was that supreme being, but you cannot see the picture of the being, but the other people are like chiefs also in white robe, I was the only person being taken to this man in black robe, then this person that I see as supreme being now said remove his black robe, I was de-robed and was given a white robe and I wasn't dreaming. This wasn't a dream. I was just looking at a particular corner and the picture started forming. I had to run out the second time. So, that is the picture I have ever witnessed. What you said that there could be a sixth sense, that is what I have come across in my life

Question 18: That is just an information, I was trying to share and that is an interesting one you have shared with me.

Interviewed: And I have never been mentally deranged before

Question 19: You are a producer, you the media play a crucial role in providing information about mental illness

Interviewed: That is why the media is there, that is why you are here otherwise, if you have not seen anything that is relevant in the movie that is worth asking question about, you will not be here, because anytime I pick up a script, the first thing that comes to my mind is there any message for people out there, if there is no message, I drop the script, because I want to preach, I want people to pick something from it, and during when I am preparing for a location, I see that that script has no message, I drop it, because there is no point going out there to make a movie that people will not learn one or two things from. There is no point.

Question 20: So far so good, what has been your major source of information about mental health care?

Interviewed: Hmm apart from, I really don't have any source of information but what I know is that when the script came to life, I had to visit Yaba to probably know some other thing I have not been told in my life

Question 21: Do you venture into reflecting the common notion about mental illness in the movies?

Interviewed: Hmm hmn! Not really, not really, not really

Question 22: Does your choice of movie content reflect the prevalent perception and information available about mental illness? In your own view, do you think the content of the movies reflect the prevalent perception and information available about mental health?

Interviewed: I just made that movies, like I said, I want people to learn from it and I do not see any reason, if I don't feel that it is worth what is to be released, that people can pick from, I don't do it.

Question 23: What would you say informs wide spread common use of traditional mental health care in our movies?

Interviewed: I think people proffer solution from what happen within their immediate environment

Question 24: From your view, as the traditional mental health care completely healed a mentally ill before?

Interviewed: I have just given you an example of a lady, she was been taken care of by a traditional medicine man, but then I noticed that when she was not with anybody she talks alone, the lady been taken care of by the traditional medicine man, we all feel as it is that she is okay, but I have noticed that when she is alone, she speaks alone.

Question 25: she was actually taken care of by the unorthodox care giver, was she ever taken to the professional?

Interviewed: ah, I don't think so. No, no, no.

Question 26: If reasons and causes of mental illness as explained by the professional and orthodox mental health care were adopted in the content of movies produced by Nigerians, would the essence of the story line in the movie be forfeited, that is if you adopt that the reason why this person in your movie, for example Enitan's mother was ill was due to maybe stressors like the fact that her husband married another wife and he is not taking care of the son, those are stressors, the professionals call them stressors which could emanate from being depressed. Instead of been depicted that her other wife, Enitan's step mum charmed her, if you had adopted that orthodox professional causes of mental illnesses, will the essence of that story line be forfeited?

Interviewed: Yes, because it will be too, as far as I am concerned, for a story writer, it will be too weak. Our viewers are the problems that we have, they will not believe it. You know, if it is English or if I had belonged to another society that is not Africa, they will take it from me because we worked towards the woman being depressed and feeling that she is a failure and all that, because you can be mentally imbalance if you feel you are failing in life, time is going, how do I make it in life, you know you could feel, that kind of thing can set in but then my society will not believe it. They will say that how can a thing like that make her mad, doesn't she have hands and legs, she can go out and work and make ends meet, they will not believe it. You have to attach some other things like bringing the junior wife to doing that bad thing and she has been told that anytime this woman gets remedy, the thing will come back to you.

Question 27: Do actually tilt towards reflecting the widespread perception about mental illness in order to ensure acceptability among the viewers?

Interviewed: Yeah, you have to do that because it is part of the message you want people to learn from, you have to tilt to satisfy your audience and make them believe what you are writing about.

Question 28: Would this acceptability wane if the medically approved perception about mental illness were adopted?

Interviewed: Yes it will, it depends on how you table your story before them. If you table your story well and they reason with you, of course you will be accepted. It depends on how you give it to them, as a movie producer.

Question 29: do you think the media plays any role when it comes to shaping the society and nurturing the views and perception of people about mental illness?

Interviewed: Of course, the media informs; print media, electronic media, the film too is electronic. Yeah, they preach because it is a way of taking what you have in mind to them and let them see the picture or read it. That's it.

Question 30: What will happen if you, considering what you said that the media informs, if they adopt that method of informing them about orthodox / professional medical mental health care, what would you say that movie is doing?

Interviewed: It will take the message to them, it will get to them and they will get to know that orthodox medicine too could do it

Question 31: And if that is done, will that still ensure acceptability among the people.

Interviewed: it will! it depends on awareness, if you make people aware. You see, all these things we are talking about we have to put into consideration that everybody that is educated, the level of education too has a lot of roles to play and not everybody has access to these film we are talking about, some people in Mushin, *Ibadia*, slum areas will not see my movie as something fantastic but if they see a movie by *Baba Suwe*, or any other comedian, they will accept it and grab it. Some people in Ikoyi, some elite will see my film and will reason with me this is a good film but the percentage off these people, of these elite is just minor. It may not really get to too many people the way any other film that doesn't even preach anything will get to people in the slums. They want to see a comedian and laugh and forget about their sorrow for some moment, but my kind of movie, probably some elite will see it and say, okay, orthodox medicine can go a long way to do this, okay you can really have orthodox and unorthodox together, is it possible, do you understand now. People that will reason with me will be minor.

Question 32: Would you say that like the media informs, would you say that what we have in our media, can't we say that there is recycling of idea between the media cont...

Interviewed: We can have a change to stop the recycling if the average number of the society were educated. The problem we have is education. Some people don't even know that, when you say that a typical Nigerian person who is not educated, you say somebody is mad and you are taking that person to the hospital, he laughs at you. Take him to *Baba Alawo*; the local medicine man, let them give that person and that person is well. That is what it means because he is not educated enough to know that there is somebody called a psychiatric, Neuro – Psychiatrists like you said, you know all these people don't even know they exist. Education needs to play a big role in informing. We need to educate these people to inform them to reason with us.

Question 33: What kind of education are we referring to?

Interviewed: school education. A lot of Nigerians are not educated

Question 34: about mental illness or general education?

Interviewed: General education, you know your abc, you know I need to read the Bible or the Quran, but if you don't know abc, you don't even feel concerned

Question 35: after speaking with some psychologists and some psycho therapists, amazingly, a lot of people who are educated still subscribe to the unorthodox form of mental health care. I will give you a scenario; I was going and all of a sudden I saw a woman who passed by me aggressively

Interviewed: Why don't you see Enitan in that picture too. In fact, let me tell you, the fact that you are going to school does not mean you are educated. You can be a PhD holder, you can have your doctorate but you may still believe in unorthodox. Of course, it's happening, we have so many people now here who people that you still need to speak Yoruba in the assembly, national assembly or the state assembly. They still want to speak Yoruba, they don't think that their education must reveal in what they are saying. The same thing applies to some people that are educated, they still believe in local things.

Question 36: Are you aware of the fact that psychiatrics and psycho therapists are not happy with the depiction of the mentally ill in the content of movies in Nigeria?

Interviewed: I am not aware they are not happy, let's ask ourselves, what do we do to make the society believe in them. You think my movie can do that? I will write a script to that effect

Question 37: with movies, you get to the grass root and that is why I said are you sure you are not recycling

Interviewed: Our society, people who buy our film at times, when you think about them, you will ask yourself, will they buy this film, will they believe what I am doing so you don't waste money, so you give them what they want.

Question 38: What can be done differently?

Interviewed: Let government give us money to make movies that can correct some societal ills, that can be done the right way that can preach to people. If you make a movie to tell the world that orthodox medicine can cure or can make somebody that is deranged well, such films, you don't sell it, give them money to make the film, to have mass production, give this film out to people in the market, in the banks, let them go and watch it at home. It is when they watch it, and say this film was given to me free, let me watch it, they learn from it, they enjoy the film and it still preaches to them that thing can be done the right way like this, like this, like this, of course they will reason with that. but we are giving them what they want to see so that our money will not be wasted but if the government can say take money, make movies, after all they give money to film producers to say that this governor is a good governor and people will watch it at home and say so Aregbesola, ah I will vote for Aregbesola. I know how much they give to people to say Goodluck Jonathan is good, so let them give money out to film producers to make about things like that too. This will go a long way. Such films, you don't sell them, even if it is thirty minutes film, give the CDs out in the market for people to watch at home. And you write it at the back of the film, free so that people don't sell it. People will reason. But as it is, if I make a film, if I spend my time and spend three million naira to make a film, I want to make at least 3.5 million

naira but if I do it the way you are saying, people will not buy, don't mind that producer, he is saying that if you are mad and you are given tablet, you will be well. You have to really give them what they believe in. that is why it looks like they recycling.

Question 39: From your experience now, which between the orthodox and the unorthodox provides the best solution for mental illness?

Interviewed: My belief! My believe is that if one gets mentally deranged via drugs and all that, if you go to a psychiatrics, they stop you and you are rehabilitated and the give you some other drugs that will make you balance, you can be cured, but if diabolically through fetish things somebody is made mad, you have to approach it from the fetish way. I know they people to church because of mental whatever but I really don't know what happens because it doesn't really work at times. When somebody goes to you say he is mentally deranged and you take that person to church, prayer, prayer, prayer, I have never seen anyone that worked. But I believe that if somebody puts two and two together and makes the other person mad, you have to go back to that kind believe and make that person well, but if it is through probably by mixing up with bad friends, into drugs, you start misbehaving, orthodox medicine is the answer. There is no other way out.

Interviewer: Thank you

TRANSCRIPT OF INTERVIEW: PRO TWO

QUESTION 1: can I meet you briefly?

INTERVIEWED: My name is ..., I am an actor and film maker.

QUESTION 2: how many movies have you made so far?

INTERVIEWED: yeah! I have done four feature films and a few documentaries.

QUESTION 3: Have you produced any movie that has depicted mental illness of any sort?

INTERVIEWED: Ah ah! No. I have not done something like that, of course depicted,... well what I have done that has to do with depicts a bit of myth and demystifying or rather the power of the gods and how people relate and associate God and evil to our day to day doing. I think the film that really depicts that is "*Irapada*" and "*The Figurine*", but of course, it didn't cover the area of mental health or anything.

QUESTION 4: how do you come about the stories you write for your production?

INTERVIEWED: Most times, I come up with the original idea, take for example "the figurine". What really inspired "figurine" for me was the fact that I looked at our environment, to me, an average African, especially Nigerian is superstitious. When we have problems or when we have issues, we tie it to either God or devil or Satan without looking at our own shortcomings. So, that was how I created the story around "the figurine" which represents the god and try to also attach a lot of catalyst where

people now start thinking, ok is it a coincidence or is it the god. So you get people thinking.

QUESTION 5: I have tried endlessly to lay my hand on “the figurine”, but a friend of mine who watched told me there was this element of paranoia in it. Was there any aspect of hallucination in “the figurine”, like the sixth sense or seeing things, was there that part in it?

INTERVIEWED: it was in the form of a dream not really hallucination. One or two dreams that one of the character had, at the end of the day, of course, the whole thing ended up happening.

QUESTION 6: what ended up happening?

INTERVIEWED: the figurine coming to her in the dream and in real life, it is right there to her face itself and it turns her to, you know of course, she gets a bit unbalance, mentally, after the experience of appearing and reappearing of the figurine, and all of that.

QUESTION 7: what was that depiction of mental imbalance, was she bizarre?

INTERVIEWED: she was quiet. First of all, after the thing happened, she picked it and in trying to dispose it, because she was heavily pregnant and she lost the pregnancy, and since then she became a bit unbalance. Most times, she just cries and sometimes, she just looked on even when the doctor is attending to her, she is just looking and that's it.

QUESTION 8: what informed that idea, that depiction, I mean, usually, in some other movies, what you would see is a complete and outrageous display of mental illness of somebody who is out there on the streets, dishevelled?

INTERVIEWED: for me sometimes its, when you are shocked beyond, for me, I would rather depict it in a subtle way where you just look on. Its seems you are staring but you are not staring at anything in particular, and because you have your brain already messed up, and for me, that is the best way I could portray such situation.

QUESTION 9: medically, what was the medical explanation for what she was going through? We can't just say she was just unbalanced.

INTERVIEWED: it's a shock. Sometimes when you are in shock, you can get, what's that word... there is another word. I can't remember right now, like when you are totally out of... I can't remember the word now, but you know sometimes shock gets you there, when you are being diagnosed and they wait for you to come back.

QUESTION 10: how much do you know about mental illness?

INTERVIEWED: Nothing. I don't know anything about it

QUESTION 11: that is a very straight forwards answer. If you were to do any movie about mental illness, what will you do as your first step?

INTERVIEWED: I will look at what we have around. Even, there are some people who seem mentally balanced; who dress normally, but they have mental illness. I think I

have even come across two people, I got to know that while having a conversation with them and maybe my perception might be different to someone else, but I engaged a few people and my conclusion is ; this person is not mentally balanced. But in the outer world, they look good and dress well but when they talk, they say things that are unimaginable.

QUESTION 12: if that is the case, if you were to advice such a person, what will you say to him or her?

INTERVIEWED: of course, I won't say to the person that you are not mentally balanced. But it will be impossible especially when that person comes to you like he knows what he is saying and maybe really nobody has ever mentioned it to him and it will be so stupid, I mean it will be an insult, I am sure the person won't take it lightly when to him he is normal and you are telling him he is crazy. I can't. You can call someone who is close to the person. Recently, some elder in this industry somehow started sending me some texts and emails that got me worried. Like someone calling you 6: 00 am in the morning and was saying something that was totally out of order; like Kunle I want to do this and police came and all the things he was saying, I couldn't put them together and I had to call people. I said look, can somebody go to this man's house and make sure that he is okay. Later people confirmed to me that there is actually a problem. He wasn't. here is somebody that talks normal but I guess maybe out of depression and that really got be worried and I immediately deduced that there is a problem even from the conversation.

QUESTION 13: you used the word depression, you actually said you don't know much about mental illness, and that's coming from the world and realm of mental illness. Other than the fact that you asked people to go there, if you were to do something radically to help the person, what will be your first move, other than the fact that you called people?

INTERVIEWED: apart from calling people, I already called a psychiatrist and called a friend who is and elder who knows a psychiatrist personally in Yaba and the person lives not too far from the psychiatric hospital. I said, please, go and check and if he confirms, let's quickly get this doctor to attend to him. That was what happened eventually.

QUESTION 14: so, in other words do you have a preference for the traditional mental health care intervention or the orthodox mental health intervention?

INTERVIEWED: sincerely, I don't know. I am a free thinker and whatever works, I don't have a mentally derailed person in my family, probably that would have helped based on experience. But I know that every religion has got their ways of resolving or solving things. Like today, my son has rashes and we have been using all sort of ointment, and my mum said we need to do the "agbo", and I said, 'go ahead, let them go and do it'. Because he has had it for so long and it won't go. Which is why I said it is always good to be open to different ways of solving problems.

QUESTION 15: when you have to, would you choose a popular or certain idea. Would you rather opt for a popular notion or attitude or belief people have about things or would you like to inject

INTERVIEWED: sincerely, I might not be able to answer that because it depends on what frame of mind or rather the structure of the story. If I want to preach something, then I will preach what I want people to believe but really, I always like to balance whatever it is I do. But I believe so much in culture, I believe so much in the Yoruba culture and I am one of those who would totally condemn when anyone comes and says this is the only way. I always leave it open and you can see it in all my films. I like to show that everybody is entitled to their beliefs. In such case, it depends on what I want to project.

QUESTION 16: talking about mental illness, the reason why I went into this research basically is because I see that a lot of people are ignorant when it comes to the first aid, what I get to do when a relative or friend is acting funny. And often times than not, loved ones, maybe because of the proliferation of movies and what we see on TV, in fact, it's amazing to know that psychiatrist are offering the option of balancing traditional mental health care providers and also inviting the professional mental health care providers, and striking a balance between what they have to offer. Yes, they may have a lot of things going wrong that the traditionalist apply such as tying a person down and employing some other method. But for crying out loud, *Aro* started off as a community based mental health care service provider and before the '*big Aro hospital*' came into being. It started like a local thing and there was a fusion of what can we do together to make this work. Basically, it is not a function of completely condemning what the traditional mental health care providers do, but doing it right matters. From my experience, I have come to realize that a lot of people who consult mental health care providers end up degenerating and in the end, if they go to the bio – medical mental health care provider, they end up getting much better. And it brought to my mind, if there are viable, efficient options, why don't we project it to the people. This is a research; I am just going out there to investigate what role the media is playing as a mass communication student. I have my B.A and MSc in mass communication and now my PhD in media studies, let see what role the media is playing in shaping the belief about mental health care either traditionally or bio medically. So, my notion is, my point of view is. I am standing on the fence as a researcher. I am not holding on to a particular belief. I just want to know what role. You are a movie content producer and you play a vital role because whatever it is that you, that is why the media is a very crucial part of our lives. We drink in, we sleep we do everything the media tells us to do. Some argues against that, but the truth is there is a magical media effect theory that we all know works. What I want to know is if you as a movie content producer had to do something, regardless of the fact that movie making is a money making venture, are there other things you put into consideration when making your movies?

INTERVIEWED: it's basic. Films are also used as corrective measures in societies.

QUESTION 17: do you strongly believe in that?

INTERVIEWED: yes

QUESTION 18: do you work towards that?

INTERVIEWED: yeah, I do that. Like you rightly said, audio – visual media is the strongest platform where people get influenced. I did a series of documentary for MNET on the History of the Yoruba's. There are two episodes that are very close to my heart is traditional medicine and the other one. In those episodes, I interviewed some

“*Baba Alawo*” who talked about the function of a “*Baba Alawo*” and was through it that I realized that there was a big difference between “*Baba Alawo*”, “*Onisegun*” and “*Adahunse*”. The *Baba Alawo* are like the doctors or physician, while *Onisegun* are the pharmacist. They are the one who put leaves and herbs together, and the *Adahunse* are the soothsayers. They are the ones that will say don’t go out in the sun, some are real, some of them are not. And they are in the other doctrines like that. Also showing more about interviews, I interviewed the “*Onisegun*”; those who mix herbs in *Osogbo* and when the documentary was shown, I got calls from different people for phone numbers of those people. Some said that their daughter has been trying to have a child, one is pregnant. Because there was a man whose area of specialization is to do delivery for pregnant women. For me, I have informed people and to an extent, it worked and if they try it and I worked, it’s up to them. I have been able to document all of that.

QUESTION 19: do you consider the media a major role player in influencing perception about issues?

INTERVIEWED: of course, yes.

QUESTION 20: would, you say that whenever you make movies what you are doing is mirroring the common believe amongst the people?

INTERVIEWED: To an extent, yes. And also, you are imposing your perception on people. That is what it is. So, it is left for them to either take it or to condemn it, but the power is in your hand to say, look this is the way. People can now say, no, it’s not the way. You have the platform to do that.

QUESTION 21: you have said you actually you try to hold the middle ground, but then, you must have your preference. In the case that you have to suggest to a relative, which will you suggest; traditional or orthodox mental health care?

INTERVIEWED: if anything happens, like I said, I don’t even know where they traditionally heal mad people. I don’t know any. So, I just informed you of the case I experienced and my first referral was Yaba Psychiatric Hospital cause that is the first and most ideal place to first consult. And sometimes, I have heard of cases where and this is like coming from doctors, patients is taking to psychiatric hospitals, and they try every standard and normal thing, and the person doesn’t get healed. So, it is suggested to the person that would you like to try the traditionalists?

QUESTION 22: have you actually had this experience?

INTERVIEWED: I have heard that from a psychiatric doctor.

QUESTION 23: that’s interesting because part of the research design I am employing is that I am actually interviewing Consultant Psychiatrist and Psychologists, so I am weighing the two views. Professionals; when I say professionals, I mean Psychiatrists and Psychologists, aren’t entirely pleased with the depiction of mental illness in the movies, what is your take on that?

INTERVIEWED: there is nothing they can do about it. Or, let them make propaganda films that will show how it is to be done. A lot of people in this industry are not trained. They are just telling their stories from their point of view because they don’t even have the resources to do a lot of research, so they care less about it and they

follow these tradition of what they have seen and how they have seen it, and people that have done it in the past. So if anybody wants to portray a mad person in the film, they will tie them and they will take them to where they are chained to the tree or rather if that is the way it is portrayed. Like I said , modern health care have budget and they do research, maybe they should raise budget and do informative and educative movies that will enlighten people on what to do when they experience it. The truth is we don't have the psychologist, is there any, but of course abroad, a lot of people always refer to psychiatrist or psychologists or a therapists.

INTERVIEWER: we do

INTERVIEWED: well, it is not known to a common man. Common man don't experience it. It's only among the elite. It's only those who have been out there would get such advice to go and see.

QUESTION 24: do you that there is a department at the Yaba Neuro – Psychiatric Hospital that is basically a Psychology department?

INTERVIEWED: tell me if, because I haven't and I grew with people with different level, different classes of people and nobody has ever said to me, 'I am going to see a psychologist. And I ever never seen anybody refer anybody to go and see a psychologist because, for you to even identify someone who needs a psychologist, you must be deep yourself. But, in Nigeria, it is a rat race. People just, we are not all mentally balanced because that is what and how the society as groomed us and we just assume that something that is not normal, we just assume it is normal. And that is just how it's been since I was borne. And we just think that it is our ways of life. Sometimes I joke with friends and I am like, look, if any psychologist open a shop or any therapist, he won't sell. He would only sell among the elite. How many times do people check there BP. Sometimes it is ignorance. There are some things that will work in the western world that won't work here. And there are things that work here that won't work in the western world. Everybody just have there. I watch a lot of documentaries, and I have seen different countries and how their beliefs influence they deal with things like this. I have seen a documentary where somebody has on open wound and they had to get maggot from a rotten animal or something and they put it there and the wound closed and they didn't end up stitching and all of that. So, everybody has got there ways of dealing with different issues

QUESTION 25: you actually acknowledged ignorance among Nigerians, you made reference to societal features with its contributory effect on our mental state of health, is it positive or negative?

INTERVIEWED: I think it's both ways, because sometimes what you don't know won't hurt you, and sometimes it is better to know it so that you can deal with it on time. So, it depends.

QUESTION 26: what would you do differently, if you had the chance?

INTERVIEWED: how?

QUESTION 27: if you are given a grant to make a movie from the government, what health related project would you embark on?

INTERVIEWED: whatever project I am doing, if its health related, I would always do my research very well and make sure it is balanced and standard. I will never compromise in such area because I won't want people, because my brand cuts across all levels of the society. So, I won't want anybody to come and say, 'that is wrong, we don't do that, even doctors'.

TRANSCRIPT OF INTERVIEW: PRO THREE

Question 1: thank you very much sir for approving this interview. My name is Khadijah Aroyewun – Adekomaiya , can I meet you please Sir?

Interviewed: my name is ..., film maker and I also manage ... Productions.

Question 2: how many movies can we say is to your credit Sir?

Interviewed: ... production opened shop around 1991 and since that time, we have made about fifteen movies.

Question 3: of these fifteen, how many depicted mental illness?

Interviewed: people remember "*Tolu Wa Ni Ile*" which dealt with the issue of environment. Actually, it was a film, "*Ayo Ni Mo Fe*" that deals with mental illness. *Ayo ni mo fe* suggests that mental illness can be managed and that people who live with some mental condition can be cared for and if there is an intervention and they seek medical help, the person's chances are that they can live normal life.

Question 4: how do you come about the stories you write for movies?

Interviewed: well, actually a lady brought an outline of a story of a jilted lover which resulted in mental illness. So, I took that and approached the Psychiatric Hospital in Yaba and approached a friend of mine who is a Psychiatrist. He went through this story and then gave me tips and guidelines as to how this person could be helped. And that was the sort of background information that we needed to approach what ordinarily would have been a local story.

Question 5: other than *Ayo Ni Mo Fe*, do you have any other movie that adopted traditional mental health?

Interviewed: we have really been very careful about the use of traditional help. Rather than that, we went to orthodox medicine and see how we can explain the situation in a way even if presented locally can be understood. We in Mainframe Production use our culture a lot, but then we want to bring it to contemporary times and we try to analyze. For example, if you take a film like "*Thunderbolt*" also "*Magun*", whether "*Magun*" is a reality or myth. That film looked for a collaboration between orthodox and our traditional medicine we suggest see if the two of them can work hand in hand, rather than one posturing as being superior to the other, and being arrogant about the monopoly of knowledge. That was what we suggested and if you look at the film like "*Arugba*", we talked about health issues; like HIV/ AIDS, Oral Rehydration Therapy and things like that within the culture and contemporary times.

Question 6: is what you are saying that when you try to make a movie, you want to solve a particular problem?

Interviewed: when we make a movie, it primarily has to have a high entertainment value. Then we look at themes and then we look at any appropriate themes we went to address at any particular time. For instance, it wasn't difficult too *practicalise* what we suggested in "*Ayo Ni Mo Fe*" because in real life because I can't disclose who it was, but there was someone who had a baby boy and the she was vagrant. Vagrant in the sense that with her condition, she lived outside in the open and so on and from Mainframe, we took her to the hospital. She was treated for about one year and, she came out of the hospital. She is back with her family and this shows that what we suggested, we actually practiced it and we are happy now that the lady now is like a member of the family.

Question 7: that is outstanding I must say. If you are of the opinion that we should marry the mental health care with the orthodox mental health care, how do you think that could come about?

Interviewed: well I think, you can verify that South Africa did a better job of it by inviting the traditional healers and took a sampling of the herbs and then went to study them, and started to extract some of the properties that are in these drugs. So, there are so many things that we can do about it. I heard in the example of child health in the example of what Ondo State Governor by starting their B.A program that is looking at maternity and child care. Traditional healers were encouraged to contact the hospital to register people who come to them and so on. I think such programs can benefit the society.

Question 8: would you say that the contents in Nigerian movies about mental health are reflectors of what we have in the society?

Interviewed: the society, although is changing but attitudes die hard. Most of the people who make movies don't bother to research. They just want to highlight the sensation to sell their product and that could be harmful to the society itself. That could keep people in regression if care is not taken, because Africans generally are anxious about their future, their status and their level of security and therefore we seek traditional help from people who can exploit them rather than solve their problems. In some cases, the films reinforce the negative aspect of our culture which is bad. It does more harm than good.

Question 9: I am sure you have been in the business for God knows when, say twenty years?

Interviewed: Forty years.

Question 10: Wow! That is phenomenal. Now would you say the media plays a role in shaping peoples attitude towards a particular issue?

Interviewed: I think that is what the media should do. The media should be concerned about societal issues. In other words, media should be making meaningful product, meaningful to form agenda for development and I think the media can do more. And right from inception, we had a mission statement in Mainframe production that we are going to try to promote and preserve our culture and that we are going to

make socially relevant movies, which is consistent throughout all of our films. We need to encourage the media to start making socially relevant films or media.

Question 11: you actually said that during the making of *Ayo Ni Mo Fe*, you approached professional psychiatrists to gather information on how people can be helped. In all of the movies that you've made that depicted mental illness. Was the orthodox mental health care the style that you adopted or you adopted the traditional mental health care?

Interviewed: in some of the movies, if we needed to use some aspect of the, for instance, in *Ti Oluwa Ni Ile*, we actually worked with an *Ifa* priest and it is interesting that even in the *Ifa* priest, there had been in our research, we found out that *Ifa* had talked about the environment and all these issues. *Ifa* in that instant, as some people have suggested that is *Ifa* scientific? *Ifa* is not scientific but it has science. That is *Ifa* mathematics, *Ifa* is not mathematics but it contains mathematics. That is *Ifa* philosophy, it is not philosophy but it contains philosophy. Any time that we wanted to research a material, we would go and find out what was appropriate in what *Ifa* is doing. There is a lot of information if you researched, that you could find useful and could be embedded in whatever you are doing.

Question 12: if you had a choice of choosing, let's say you receive a huge financial backing towards eulogizing the traditional mental health care as against the orthodox mental health care, what would you do?

Interviewed: first of all, I will seek a connection between the orthodox and the traditional because some of the traditional mental healing methods are not documented in a way. They are built around the charisma of the healer who may die and all his wealth of experience die with him. The other is to, perhaps, the orthodox medicine have done something about looking at the traditional healing methods in mental illness and perhaps have sought to improve it or to give them suggestions. I don't know how far because the way from our treatment of mental illness, from healer to healer, it's not standard. And people do weird things to their patients and to think that most of these things is spiritual and tackle it from the spiritual realm. Even patients are chained, deprived tortured, so there has to be an understanding of the nature of the illness before anybody can claim any time of healing.

Question 13: truly, many of our movies depict the traditional mental health care, if I am quoting you rightly, you said they are reflectors of what we have in the society right now? People often opt for the traditional mental health care which supposes why our movies reflects them?

Interviewed: yes.

Question 14: if that is so and as a movie maker, would you suggest that people will tilt to professional mental health care if our movies were to adopt the orthodox mental health as a choice in seeking help. Will that influence a change in the attitude people have towards seeking professional mental health care-providers.

Interviewed: yes that is what will happen. That is the power of the medium itself and the media is very close to the grass root. If there was motivation, and if there was consistency in series of movies around this subject matter. There is no doubt in my

heart that there would be changes. We tried it and we practiced it and we just wish that there are many more like that.

Question 15: which of these available mental health care providers- the religious intervention, the traditional or local intervention and the orthodox intervention do you consider more reliable and efficient in helping mentally ill patient?

Interviewed: I think that without doubt, the orthodox medical practice for me does that because it is organized, it is scientific and it provides relevant data that and its institutionalized. From institution to institution, you have people who are highly trained and are dedicated to deal with these types of issues. We did a program once about a woman who suddenly started to confess that she was a witch that she caused a lot of mischief and claimed that she has harmed a lot of people, the young in the household, prevented them from getting married and all that. And usually what happened in such thing is to instantly punish. Maybe lynched, maybe burnt alive for confessing as a witch. And we have done a program around it and I went to my friend and said look this is a program, if you can watch it on television. There were shocked and could never forget because they told me that such manifestation is nothing more than the symptoms of *manic* depression and that the victim will generally talk like this and imagine these situations and claim to have done that. They said that if that person has not been killed by now is lucky. And they challenged me that with such mental intervention, treatment, that I will be surprised at the transformation of three to four weeks. It shows that if we put information out there, we can save lives and definitely change people's attitude towards mental illness. Any time I go there to see my friends who are Consultants, you can see result and you can see hope for victims and you can see that it is even random. People whom you can't even imagine will walk into the institution, it depicts people from all strata of the society are treated regularly, but because of the stigma, people don't say that they are patients. So for me, it remains the best hope of providing care for the mentally ill in the society.

Question 16: professionals are not pleased with the way mental illness is depicted in the movies, what is your response to that?

Interviewed: yeah, that is why the Nollywood workshop has a health based organization that has just been formed called "GIST". From conception of an idea before making it into a movie, film makers are encouraged to go to them and they look at it from the health point of view and they give professional advice and suggestions.

Question 17: what organization is that please?

Interviewed: it is an extension of Nollywood workshop which you can google. They have the GIST program which is basically health issues and these are formed to guide media people or film makers in their production of films that have health themes.

Question 18: Was that an idea that emanated from the Nollywood itself or a group of health officials decided to work at par with the movie makers to make this happen?

Interviewed: The director of Nollywood movies is based in the US. She is based in Harvard University and she has done a lot of work in Nollywood here and that is the latest addition, the GIST program which is to encouragement based media.

Question 19: do you consider the content of your movie having an impact on the perception of the mentally ill and the approach to treatment by people who see them?

Interviewed: unfortunately, there has not been a track. I don't know of many movies with mental themes. Most of the ones that I have seen tend to exploit the negative aspect of our culture and then the mental cases are suggested to have come from people who have caused people spiritually for certain reasons, some of which are a sort of retribution of some of their past, maybe what they had like a fight or something and have thus being afflicted with mental condition which for me is more fabrication than reality which suits a particular situation. But there are not many who approach it from a medical point of view which *Ti Oluwa Ni Ile* we need many years ago. There is not enough good movies to look at the theme of mental illness in a progressive or look at it in contemporary health care.

Question 20: If you had a chance to make a difference in the world of mental health as a movie maker, what are the things you would do?

Interviewed: It would have to be perhaps a remake of *Ayo Ni Mo Fe*, perhaps we have more resources than we had. Therefore, having had the opportunity to update what I know about mental illness and could certainly do something tangible with the theme. And it is a shame that from then and now, the mental health care has even deteriorated, because I continue to maintain a good relationship with the health institution and I am so disappointed that ten years ago we had better mental health care facilities than we do now and when I spoke to the Medical Director of the Yaba Neuro- Psychiatrists hospital for instance, she told me that because of some certain problems, that the number of the patients in the hospital has even reduced considerably to not more than thirty and it is sad to know that presently, people living with mental illness are neglected.

Question 21: Would that be your final note sir?

Interviewed: my heart goes to people living with mental conditions because it will appear to a layman that the government is not treating it with priority and therefore, they are in need and they are completely. For me the government could do a lot more to support these institutions because of their importance in the lives of people and in terms of our national development.

APPENDIX G

MOVIE 1: *Egwonga* - The Deadly god (2014)

Egwonga is a story of a widow, Orguigo (Ngozi Ezeonu) who was accused of witch craft in an Igbo community that claimed that the advent of Christianity had abolished the existence of shrines and all activities indicating idolatry. The accusation of witchcraft surfaced when the villagers interpreted the catastrophic death of Orguigo's three sons in one day, father in law and husband as her doing. They threatened to burn her alive if she remained in the village within seven days. This made her to take refuge in the deep forest, though leaving her only surviving daughter, Ugomma (Queen Nwokoye) in the care of Ugomma's uncle. Orguigo sought help from a particular tree for protection and made an allegiance to give her daughter (Ugomma) to the enchanted tree as a wife, and avowing also that that no man would be allowed to have a sexual relationship with her daughter, Ugomma.

Twenty-seven years later, Ugomma grew into a beautiful woman whom traders loved to give their wares to for free, simply because they attributed good luck to her. On one of the days she was returning from the market, Orguigo laid in wait for Ugomma and asked her for food. Ugomma gave her some food and the old lady gave Ugomma a necklace as a gift which Ugomma always wore on her neck. Ugomma had grown and was ready for marriage, but no suitor came to ask for her hand. This attracted insults from contenders in the village and worried her uncle, who took charge of rearing Ugomma after her mother left on exile.

A male visitor from the city, Evander (Artus Frank), met Ugomma while she was despondent. Evander comforted her but also took away her virginity, which her mother had avowed would be kept in sanctity. This annoyed the enchanted tree and caused chaos in the village as heavy thunder claps enveloped the village and the enchanted tree began to bleed. This worried the villagers, as people began to die from sudden diseases or horrid incidences which pushed a group of elders to consult a *Dibya* (herbalist or traditional priest) at the outskirts of the village for explanation. The *Dibya* explained that Ugomma is the wife of the spirit or god that resides in the tree and that she has been defiled. She is to confess to this act and must be sacrificed to appease the angered god. Ugomma refuted this allegation and an attempt to stop the menacing actions of the bleeding tree led to the death of some men and women including Ugomma's uncle. This happened during an attempt made to combat the enchanted tree with prayers in the Christian way by a Reverend and some church participants.

Plans were eventually orchestrated to take Ugomma against her will, but Orguigo visited her daughter and told her to leave the village for the city at the break of the dawn. Ugomma found her way to the city in search of Evander and began to live with him. Evander began to grow in wealth and status as Ugomma would always insist that she gives good luck to whoever is kind towards her. It turned out that Evander preferred Ugomma to his girlfriend and they began to live as man and wife.

People continued to fall sick and die at the village, but the appeal from Orguigo (Ugomma's mother) to the enchanted tree fell on deaf ears as it insisted that his wife (Ugomma) be returned to him for sacrifice. The enchanted spirit paid a sudden visit to Ugomma in her new home in the city, but met with reprisal from Ugomma as she emphatically stated that it was impossible for her to be married to a god or spirit and that she cannot be betrothed to a spirit that was abolished before she was born. This angered the spirit who struck her with magic and she began to behave strangely. She sat in the middle of the sitting room and began to chant 'Egwonga' at every rigorous twist and turn of her head. Ugomma ran away from the house after she overheard Evander and his friend conjure up a plan to take her to the village as information as reached them that she is wanted in the village for the purpose of appeasing the angry spirit, Egwonga (*the bleeding tree*).

Egwonga visited Ugomma again at the side of the street, with the same request that she has to return to the village and take part in the sacrifice required to appease him. Ugomma declined and he struck her again magically and she became mentally ill. She left her bag and shoes and started to run to no particular destination. She became a vagrant and also begged for food. She looked unkempt and dirty and lived by the side of the road. She talked to herself as no one could see the spirit except her. Several attempts were made by Evander and his friend to find Ugomma, which paid off one day when his ex-girlfriend found her under a shed on the side of street. Ugomma evaded the chances of being found as she ran off the moment she realized that Evander's ex-girlfriend called him up. She was eventually found, but she refused to be taken as she got hold of a log and threatened to hurt anyone who

came close to her. Knowing that the three might over-power her, she sought a cutlass she found at the side of the shed where she was hiding and threatened to slit her own throat if they did not leave her alone. Evander sang the same song she sang on the day they met and that calmed her down such that she agreed to be taken away.

Evander's friend sabotaged the agreement they had to consult a pastor who would exorcise her as they interpreted her behaviour as that of someone who is possessed. Instead, Evander's friend took Ugomma to the waiting elders in the village for the purpose of sacrificing her to appease the god. Ugomma was tied to the enchanted tree with a rope, her mouth was tied with a red piece of cloth, and the elders and volunteering virgin - who would now become the new wife of the god after the demise of Ugomma, were clad in white apparels. Egwonga (the deadly god) was invoked by the elders. He appeared before them in the image of a scary looking masquerade, and the elders asked him to take Ugomma who is still tied to the tree as his sacrifice. Evander's pastor from the city and the resident reverend, priest and church members of the village came together and headed towards the place of the enchanted tree. The Christian adherents prayed and sang and splashed a liquid substance - also known as holy water in the direction of the tree. The god appeared and disappeared and the harness restraining Ugomma became loose. Ugomma fell into an embrace with Evander after he reached out to her and she appeared fully recovered as the Christian adherent sighed in relief as they had defeated the deadly god.

Ugomma was reunited with her mother, Orguigo. Orguigo denounced her allegiance to the deity, which she referred to as an unforgiving deity who could not forgive her daughter's mistake despite twenty seven years of her service to it as a humble servant. She decided she was ready to worship the God of the Christians that defeated Egwonga (*the deadly god that resides in the bleeding tree*).

MOVIE 2: Aso Were - Madman's Cloth (2013)

The narrative concerns a couple who have three well grown daughters and no son. The father, Akanji (Jide Kosoko) visited his own father who advised him to take another wife so that she can bear him a son and thus have an heir that would take care of him when he grows old. Akanji refused and told his father he would not do such because he refuses to allow rivalry to thrive in his home. This conversation was overheard by Akanji's wife (Rachael Oniga), unknown to Akanji and his father. After Akanji's death, his fifteen years old daughter, Funke, conceived out of wedlock for a Prince (Odunlade Adekola) who was reportedly out of the country and was unaware of Funke's conception. In order to ensure that Akanji's family lineage does not go into extinction, Akanji's wife consulted an *Ifa* priest to reverse the sex of the fetus to a male. Several rituals were carried out and paid for by Funke's mother, some of which even involved the oral consumption of some substance that was locally prepared by the *Ifa* priest as medicine that will facilitate the reversal of the sex of the fetus to a male.

Funke's mother conspired with the *Ifa* priest on how to ensure that no one comes over to claim fatherhood of the male child when born. Hence, the *Ifa* priest conjured up a tale of death consequence to Funke (Mercy Ebosele) if she allowed anyone to claim fatherhood of the child. Funke did as she was told and Funke's mother began to dream about how well her life would change once she finally has a male child in the lineage to call her own. After a day dream of how life would become if Funke gave birth to her grandson, Funke's mother headed to the *Ifa* priest for interpretation of her dreams. The *Ifa* priest told her the dream will come true only if she gets the cloth of a madman for a ritual exercise he would need to carry out in order for the dream to materialise.

In order to fulfil the request for a mad man's cloth by the *Ifa* priest, Funke's mother approached a mad man who appeared vagrant, incoherent, dishevelled, and unkempt. Funke's mother started singing and dancing with the 'madman' just so she could draw close to him enough to cut a piece from his cloth. But the 'madman' realized this and gave her a wild chase. Funke's mother became despondent and had to confide in Funke's elder sister (Folake), who prepared a drugged meal to be taken to the 'madman' for easy operation. The 'madman' ate from this meal and fell asleep. Folake and her mother made an attempt to cut a piece from his cloth, but the 'madman' woke up abruptly and asked them what they wanted from him. Although, he kept saying words that were incoherent with the present situation, he still asked them if they wanted his cloth, which they affirmed. He gave them a wrapper he had on and told them it is their inheritance from him, acting as though they were his kids wanting to take their inheritance from him prematurely. Funke eventually fell into labour and gave birth to a baby

girl. The news of a baby girl shocked Funke's mother, which invariably led to her death on the same day Funke died from the news of a girl child and her mother's death.

MOVIE 3: *Obiripo* - what goes around comes around (2014)

The movie is about a married man, Enitan (Funso Adeolu) who engaged in extra marital affairs to the notice of his legal wife. He eventually had a child with his concubine whom he decided to stay with in place of his legal wife. Enitan is constantly in an unhappy state and falls in cry outbursts for reasons unknown to his wife. After much pressure from his wife to disclose the reasons for his constant repose to depression and insomnia, he takes his wife on a trip to the village where he reveals that his mother is mentally ill and has been in the street since he was in the University. Enitan's mother, Wura (Fausat Balogun), was found at the point of been physically assaulted by a woman who sells bean cakes (akara). She assaulted her because Enitan's mother, who appeared dirty, vagrant and dishevelled, took some bean cakes without asking or paying for it. Enitan and his wife got to the scene just in time, stopped her from the assault, paid for the bean cakes and took Wura away from the scene. Some children in the village began to mimic Enitan's mother as they started chanting "Wura". This annoyed Temi, Enitan's wife (Moji Olaiya) as she made several attempts to chase the children away from her mother in law. Enitan explained to his wife that his mother's mental state of health was the reason why he constantly cried and had insomnia. Enitan expressed his shock at how his wife only showed love and concern for him and his mother after she got to know of his mother's mental state, rather than the divorce he had

feared. Enitan's wife facilitated the decision to move Wura to a 'specialist hospital' in Abeokuta (a state in the South Western part of Nigeria) where a specialist, who combines the use of orthodox mental health care, such as injections and medications, with traditional medicine such as herbs and charms, works. There were times in the movie that the Specialist doctor would ask if the injections she prescribed has been administered; and there were times in the treatment process where the specialist doctor would place a magic like object on the head of the mentally ill. The doctor also prepared an herbal mixture from unidentified herbs, which Wura was asked to drink. The specialist turned out to be his former wife, Tina (Olajuwon Adewunmi), who he left for his present wife, Temi. Wura (Enitan's mum) recuperated and recovered fully. She recounted the ordeal that led to the emergence of her mental ill health to Temi, Enitan's wife.

The reason for the emergence of mental illness in Enitan's mother was as a result of the marital distress she had to undergo due to her husband's marriage to another woman and his neglect of Enitan and his mother, and the supposed evil intention of the new wife which translated into the diabolic infection of Enitan's mother with mental illness through the consumption of a charmed meal. The charmed meal was intended for Enitan, which his mother ate after she forgot to take it with her on the day she visited Enitan at the University. Wura revealed that her trouble started when her husband (Enitan's father) married another woman whom he was not financially prepared to take care of. In the movie, the new wife became mentally ill after seeing Wura as a consequence for magically causing Wura to become mentally ill. Enitan's headmaster (Antar Laniyan) from his secondary school took

responsibility of his education financially after observing Enitan as a propitious child. The headmaster turned out to be the father of Temi (Enitan's wife) who he could not rear because Temi's mother was taken away from the country after she conceived, owing to the disapproval of the marriage between Temi's mother and the headmaster by the parents of the duo.

MOVIE 4: *Tears of Madness* - Part One (2013)

The movie started with the scene, where Richard (Kenneth Okonkwo), Somadina (Mercy Johnson), and Ojuigo (Patience Ozokwor) are at the hospital waiting on the doctor to bring them a news of their son who was rushed to the hospital after he stopped breathing whilst Ojuigo, Richard's mother, was giving him a bath. Somadina, Richard's wife, began to look on at the hospital after the doctor broke the news of her dead son. The doctor attending to Somadina explained to Richard that his wife is better off at the psychiatric hospital as she has fallen into a "shock that has affected her brain" due to the death of her son.

Somadina was moved to a psychiatric hospital. Her ward had many beds and she was the third of the occupants in the ward. Somadina made a baby figure out of a piece of white cloth and petted it as a baby. Richard tried to take it from her but the doctor advised him to get her a teddy bear which she would treat as a baby. After sometime, Richard was advised by the doctor attending to his wife to take Somadina home. The doctor posited that the involvement of family members in the convalescence of Somadina will improve her rate of recovery. Somadina

was moved home. Richard treated her well and still attended to her as his wife. He even played along at times when she involves him in talking to the teddy bear she still treats as her baby.

Her health did not improve as she continued to display disturbing behaviour. At a time, she broke the TV when she saw moving children. She broke down afterwards, ripped apart a pillow and cried. Richard calmed her down with a certain song. They were times Somadina tried to force feed the teddy bear, and at other times, she beat the teddy bear for not passing out faeces. Richard often played along. This prompted him to return back to the hospital to complain that his wife is not improving. He was asked to bring his wife back and she was re-admitted.

An injection was administered to her when she became aggressive at the hospital. Somadina fled the hospital and took to the street. She was shown rummaging through a hip of dump with the teddy bear tied to her back with a piece of cloth. Richard and a team of others began the search of his wife. The first part ended when Richard and a search team called off their search since it yielded no result.

MOVIE 5: *Tears Of Madness* - Part Two (2013)

In the second part of this movie, Richard's mother (Ojuigo) brought a woman in Somadina's stead for her son to marry. Richard disapproved of this arrangement and advised the presented lady to leave his house, stating that he was still married to his wife, whom he loves and adore. Somadina was shown living under a tree amidst filth and looking

heavily pregnant. She fell into labour and passers-by helped her to the hospital. She delivered of a baby boy and he was declared healthy and free of any congenital disease.

An elderly woman who was among those who came to Somadina's rescue while in labour, decided to adopt the boy with the permission of her husband. Somadina constantly harassed the elderly woman by requesting for her baby. Seven years later, Somadina's son asked his guardians if it was true that the 'mad woman' who lived on their street was his mother because a neighbourhood friend told him so. The elderly couple said no and told the boy to pay no attention to the neighbourhood friend when next he says so. Richard tried to stop two boys who were in a brawl in front of a mentally ill woman, who turned out to be Somadina. Once the boy pointed to Somadina as the reason why they were fighting, Richard identified her and made towards her, but she aggressively rebuffed his gesture. He calmed her down by singing the same song that he would usually sing to her, but the period of calmness lasted only before she chased him off with the throw of a broken basket.

Richard reconciled with his son, after going back to the hospital, from where his wife ran off, to confirm if his wife was pregnant before running away from the facility. He thanked the guardians who took charge of rearing his son and avowed to take his wife home with him. Somadina refused to be taken away, but was later taken away by Richard after she fell asleep. She was locked up in a clean room at Richard's house. She sought ways to escape from the room, but Richard

calmed her down again with the song that he usually sings to her. She screamed all of a sudden, Richard rushed into the room and to his shock; Somadina had regained her stable mental state as she recognized him and called out his name. In the narrative plot, the pregnancy was conceived the night Somadina came in from the psychiatric hospital, which was shortly before her health degenerated. Richard threw a party for Somadina and his son. Somadina fully recovered and showed signs of mental illness no more.

MOVIE 6: *Elulu* - Part One (2014)

The movie started with the appearance of a mentally ill man approaching a decently dressed man and asking him if he went by the name Gbeminiyi. The decent looking man, Gbeminiyi (Odunlade Adekola), answered in the affirmative and the mentally ill man began to hit him with a bunch of cane. For every hit, there appeared an effect that implied that each hit had a diabolic connotation. Gbeminiyi was then shown wearing a pair of mismatch clothing that were not dirty, while his countenance and conversation implied the onset of mental illness. A man (who traded in vulcanizing tyres) called him “fine boy” and asked him for a number to gamble with. The man began to note the numbers that emerged while Gbeminiyi engaged in the narration of incoherent incidence. This number supposedly won the man a large sum of money at the gambling table. Ojuolape (Fatiha Balogun) was attracted to Gbeminiyi. She began to day dream about him and would even leave her office in search of him whenever she has an incline that he is passing by. Ojuolape revealed her intention to start a relationship with Gbeminiyi to her friend. So she began to look for him. Folashade,

Ojuolape's friend (Funke Etti), reported Ojuolape to her parents, stating that she is worried her friend is out to help and marry a 'mad man' simply because she finds him attractive. In a conversation Folashade had with her friend, she said, "what do you need a lunatic for? Do you know lunatics cannot be completely cured"? This conversation came up when Ojuolape told her friend she has helped Gbeminiyi and has been able to get him to tell her his name.

Gbeminiyi and Ojuolape began a relationship. Ojuolape's house maid informed Folashade that the couple usually take to their rooms while also reporting incidences where Gbeminiyi would hit Ojuolape. Another scene showed Gbeminiyi engage in physical assault of Ojuolape and her house maid. On another visit, Folashade witnessed an incidence where Gbeminiyi suddenly dropped his fork in the middle of a meal and began to ravishingly devour the meal with his hands. This behaviour stunned Folashade but Ojuolape was quick to defend this bizarre behaviour. Ojuolape eventually got pregnant and she conveyed the news to Gbeminiyi, who initially wore a shocking expression that transited into euphoria. He begged her to never leave him.

After a hand shake with Ojuolape's Dad on the day she first took him to them on a visit, Gbeminiyi suddenly began to display symptoms of mental illness. Gbeminiyi was taken to a traditional mental health care facility in an uncompleted building. He was also taken to the church where Ojuolape worships for treatment. It was implied in the movie that the pastor discerned the cause of Gbeminiyi's mental illness after praying for him: it was depicted that the pastor saw the scene from the

beginning where a mentally ill man struck Gbeminiyi with canes. But the vision the pastor supposedly experienced revealed more as the pastor was shown asking the mentally ill man to stop his actions. The mentally ill man insisted that he will not stop hitting Gbeminiyi until Ajibade instructs him to. Ajibade (Antar Laniyan) is Ojuolape's Dad. A meeting between the pastor, Ajibade's family and friend, Agbabiaka (Adebayo Salami), was held at the church to persuade Ajibade to reveal what he knows of the cause of Gbeminiyi's illness. Ajibade became angry and walked out of the meeting. Gbeminiyi's parents were informed of their son's whereabouts. They found him chained and lying on a bare floor outside of the church. The first part ended here.

MOVIE 7: *Elulu* - Part two (2014)

The movie continued by showing Ajibade when his daughter sought to kill him with a gun in a dream. Agbabiaka (Ajibade's friend) came and persuaded him to return to the church where Gbeminiyi is being attended to. The pastor called for a private meeting with the men only, as he asked Ajibade once again if he knew anything about how Gbeminiyi became mentally ill. Ajibade asked for three days to think over the request. Ajibade visited an *Ifa* Priest (soothsayer) who purportedly carried out the diabolical enchantment on Gbeminiyi by making him mentally ill on Ajibade's request. Ajibade conceded to the suggestion that Gbeminiyi be killed to avoid confessing, which is detrimental to their lives. On Ajibade's way home, he met with an accident.

Ajibade was declared dead by the doctors. It turned out that an *Alfa*, Islamic cleric, the Pastor and an *Ifa* Priest (traditional healer) that was visited by Gbeminiyi's parents all persuaded Ajibade to go back to the earth to do the right thing – which is to confess his involvement in Gbeminiyi's mental illness. The soothsayer that carried out the diabolic act of harming Gbeminiyi was presented to him as been punished in the grave for his dreadful act. So, he was told that if he doesn't want the same fate, he should return to earth to set things right. Ajibade woke up from the "dead". Gbeminiyi was shown in shackles as he laid down while his mother wept for his condition. Gbeminiyi woke up and asked why he was in chains. He appeared fully recovered. Ajibade sought Gbeminiyi's forgiveness along with his daughter's and explained that greed and anger pushed him into his actions. He claimed that he inflicted Gbeminiyi with madness because Ajibade lost a contract he has been chasing vehemently to Gbeminiyi, who was then working for his friend, Agbabiaka. Ajibade did not become mentally ill as the soothsayer had augured. Ajibade agreed to the union between his daughter and Gbeminiyi and the movie was concluded.

MOVIE 8: *Mad Couple* (2014)

The movie started with mothers of Chibuka (Nuella Njubigbo) and Chiamaka (Mercy Johnson) arguing over an issue that was raised during the meeting of the village women's organization. The tension between both mothers threatened the friendship of the daughters as both mothers tried to dissuade their daughters from continuing friendship with the other by saying mean things about their friends. Chiamaka lost the part time job she does because Chibuka's Mother

revealed to Chiamaka's employer her hideout for studying. Angrily, Chiamaka's mother visited Chibuka's mother at home and said mean things to her about the pregnancy Chibuka was carrying. This upset Chibuka a great deal and she sought a *Dibya* (ifa priest) to ensure that her friend is rendered mentally ill. The *Dibya* requested for Chiamaka's scarf, which Chibuka pretentiously collected from her friend. Chibuka was informed by the priest that the price to pay for this evil action would be that her unborn child will remain in her stomach for as long as her friend is mad and whenever she decides to have her baby, the child will come out mad. This scared Chibuka and she thought twice. She came back to the *Dibya* to have this diabolic act actualized. Rolland, Chiamaka's boyfriend (Uche Odoputa), however promised to help her financially through school while she helped him get better at his studies. Chiamaka turned out to be one of the best students in her class. She even led the other students in study groups. Chiamaka would study really hard since she studied for both herself and Rolland by helping him with the school works he could not do himself.

Chibuka gave her consent to the priest to carry on with the diabolical act of inflicting her friend with mental illness. The onset of mental illness in Chiamaka coincided with the period when she was shown studying real hard. Chibuka began to have abdominal pains and the priest told her that she would continue to have these pains for as long as her friend remained mentally ill. He promised to give her three days to have a rethink after which he would make the mental illness and her pains permanent. The three days leave implied that Chiamaka will be relieved of her mental illness. Chiamaka became better but the illness came back after some days only for her to be taken to the church by her

mother after she was informed about the incidence. Chiamaka's mother also visited Chibuka's mother begging her to please desist from the evil intent to prevent her from being a mother to a doctor. Chibuka's mother told her that she wouldn't do anything of the sort despite their obvious hatred for each other.

Rolland is the only child of a wealthy and wayward chief. His father constantly rebuked Rolland for wanting to stick to a woman who would probably break his heart like his mother did to him. Despite Rolland's insistence to help Chiamaka out by intending to take her to the hospital, his father refused to assist him with funds. Chiamaka became vagrant and unkempt as she escaped from the church. Rolland searched for her immediately he heard she had left the church, and he joined in her charade by dancing alongside with Chiamaka on the street. Chiamaka was depicted as always trying to read somethings from her palms, talking to herself, jumping over gates, running away and threatening people who gather round to restrain her. She was also depicted as attempting to jump through the window of a moving car.

MOVIE 9: *Ore Meta Were Kan* (2014)

The movie is about three friends: Akanni (Muyiwa Ademola); Ajani (Wale Akorede); and Ige (Olaniyi Afonja) The three friends made ceaseless effort to become rich. They collectively engaged in menial jobs and when that did not make them rich, they decided to consult an *Ifa* priest. The *Ifa* priest engaged them in rigorous tasks but told them in the end that seeking wealth from magical means will have a catastrophic ending. The

friends continued to hustle until Akanni got a chance to travel overseas. Akanni became wealthy, invited his mother (Taiwo Hasan) to the city, and employed his friends to work for his mother.

A mentally ill man, *Were Sharukan* (Tayo Amokade) appeared in various contexts in the narrative until he finally showed up in Akanni's house. The presence of *Were Sharukan* frightened Ige and Ajani who had to get him out of the house. *Were Sharukan* thought of himself as an Indian in his speech and dance. Ajani and Ige stole a box of gold from Akanni's mother and killed her to cover up their act. Akanni's mother reincarnated in *Were Sharukan*, who haunted Ige and Ajani in ghost-like appearances and disappearances. At the point of taking over the *Were Sharukan*'s body, Akanni's mother uncovered where the box of gold was hidden. In the end, *Were Sharukan* revealed to Akanni the truth of his mother's death and the connection between *Were Sharukan* and Akanni. It turned out that *Were Sharukan* became mentally ill when an amount of money, which an *Ifa* priest asked him to hide in a secret place to foster his plan to travel to India, was found by Akanni's mother. Akanni's mother gave this enchanted money to Akanni to pursue his travel plans. In the end, Ajani and Ige were handed over to the police. *Were Sharukan* became healed when Akanni's mother left his body, and Akanni rewarded the now healed man with money and a house.

MOVIE 10: *Ire Aje* (2014)

The story started with the image of a mad woman (Bukola Mosoban), who was vagrant, unkempt and was given a drugged orange by Akanji (Antar Laniyan) who had unsolicited sexual intercourse with her. In subsequent scenes, Akanji married the mad woman. She had two children for him, but people who worked for him thought that the source of his wealth was from his mad wife. On the other hand, there is an *Ifa* priest who chants some magical words into a screen for want of information on the whereabouts of a sister he lost some thirty years back. Akanji bore the difficulty he faced from living with a mad wife patiently. One day, he decided to follow through with the advice he was given by a domestic worker, Shalewa (Mide F.M. Abiodun), and visited an *Ifa* priest. Eventually, it was revealed that Akanji's reason for marrying a mad woman was to stop the recurring deaths of women he went out with. After the counts of seven deaths, a pastor advised him to seek a mad woman to stop the deaths of women he dates. Akanji explained to the *Ifa* priest that he had taken his wife to a psychiatric hospital which yielded no result. The *Ifa* priest consulted the past magically and it was revealed to him that a man, who turned out to be Akanji's father (Awofe Afolayan), was responsible for all the bad things that happened to him. Akanji's father was poor, he wanted to become rich. He visited an *Ifa* priest who asked him to have sexual intercourse with a mad woman to earn wealth magically. He did as he was asked. He had unsolicited sexual intercourse with a woman, who turned out to be Akanji's wife's mother and the *Ifa* priest's missing sister. Akanji's father killed the mad woman and magically turned her daughter mad. In the end, the *Ifa* priest healed Akanji's wife and she was reunited with her mother's brother, the *Ifa* priest.

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